

## School Nurse Instruction Form

Date Instructions Provided: \_\_\_\_\_

Physician Name: \_\_\_\_\_

Physician Contact information: \_\_\_\_\_

Name of Child: \_\_\_\_\_

The child \_\_\_\_\_ has been diagnosed with migraine headaches. Migraine in this child is often identified by the following characteristics:

- \_\_\_\_\_ Moderate to severe pain intensity
- \_\_\_\_\_ Throbbing pain
- \_\_\_\_\_ Photophobia
- \_\_\_\_\_ Phonophobia
- \_\_\_\_\_ Disabling pain
- \_\_\_\_\_ Nausea and/or vomiting

The child \_\_\_\_\_ has been prescribed:

- Name of medication #1 to be given \_\_\_\_\_
- Dose of medication #1 to be given \_\_\_\_\_
  
- Name of medication #2 to be given \_\_\_\_\_
- Dose of medication #2 to be given \_\_\_\_\_

***This medication should be given as soon as the child recognizes the onset of a migraine, without delay.***

Potential side effects to watch for include:

\_\_\_\_\_

If needed, please allow the child to rest for \_\_\_\_\_. After this time, the child may return to the classroom if pain relief is achieved or if the child feels they can continue to function.

**Please notify the parent if:**

- Headache does not respond to given treatment within 2 hours
- Headaches have a sudden change in characteristics or features
- Headaches seem to be increasing in frequency
- You are running low on medication prescribed for this child
- You have any other concerns