Student _____ Date of Birth _____ Grade _____

Headache Questionnaire

School Year_____

Please complete and return to the School Nurse. The following information is helpful in determining any special needs.

Person to contact:	Relationship:	Work Phone:	Home Phone:
1.			
2.			
3.			
4.			

Family Physician:	Clinic:	Phone:

Hospital:	Phone:	
		Health Insurance: _____Yes _____No

Child's age when headache/migraine started: _____

Describe what may occur: _____

_____

Please list any medications your child is taking for headaches/migraines:

Name of Medication	Amount Taken	How Taken	How Often

Please list any side effects of your child's medications:_____

_____

PROCEDURE:

1. Administer student's medication that has been ordered by the physician and provided by parents.
2. Allow student to rest in health room.
3. Ice pack upon student request.
4. Parent/Guardian will not routinely be contacted for every headache. Do you wish to be contacted? YES NO

I request the about procedure be followed for my child.

If a medication is to be given at school, a medication form must be completed yearly. The medication must be in original labeled container. (When you get the prescription filled, please ask the pharmacist to put it into two containers so your child will have one for school and one for home use.)

Are there any classroom or physical education accommodations needed for your child?

_____

CONTINUED . . .

What action do you want school personnel to take, if your child does not respond to treatment/medication?

_____

In an acute emergency the student will be transported by ambulance to the hospital. Transportation in a non-acute situation is the responsibility of the parent/guardian. Any charges incurred are the responsibility of the parent/guardian.

Please add anything else you would like school personnel to know about your child's headaches.

_____

Information was provided by _____

Name Relationship Date

School nurse may share this information with appropriate school personnel YES NO

I authorize reciprocal release of information related to headaches/migraines between the school nurse and the health care provider.

_____

Parent/Guardian Signature Date