Individualized Health Care Plan **Student Name:** **School Year:**

Headache Individualized Healthcare Plan

SECTION I			
Student:			**WT:** / **HT:**
Grade:	**D.O.B**	**Any Known Allergies**	
School:			
District:		**Bus (check one) ☐YES ☐NO**	
		Bus #AM	**Bus #PM**
School Nurse:		**Phone #**	**Cell #**
Medication taken at home: (please list)			

Contacts

Mother	**Home #**	**Work #**	**Cell #**
Father	**Home #**	**Work #**	**Cell #**
Guardian/Custodian	**Home #**	**Work #**	**Cell #**
Home Address		**City #**	**Zip**
Emergency Contact (Relationship)		**Home #**	**Work #**
Physician		**Phone #**	**Fax#**
Physician Address		**City**	**Zip**

Date	Special Notes

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SECTION II: EMERGENCY ACTION PLAN	
IF YOU SEE THIS…	**DO THIS…**
Light sensitivity	Notify School Nurse
Nausea / vomiting	Notify School Nurse
Blurred vision	Notify School Nurse
Dizziness	Notify School Nurse
Severe pain	Notify School Nurse
Other related information:	

Is a PRESCRIBER/PARENT AUTHORIZATION (PPA) on file for this student? □ **No** □ **Yes**

*** PRESCRIBER/PARENT AUTHORIZATION (PPA) is required for all medication given at school**

Notes /Special Instruction_____

_____

_____

_____

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SECTION III:

Brief description of medical condition: Headaches – A headache may appear as a sharp pain, a throbbing sensation or a dull ache in the head.
Migraine – a condition marked by moderate to severe headache that usually lasts from 4 hours to 3 days that typically affects one side of the head. A migraine can be accompanied by nausea, vomiting, disturbed vision, and sensitivity to light and sound.

Avoid circumstances that may lead to potential emergency:

SCHOOL DAY:	**PHYSICAL EDUCATION:**
Avoid triggers. Monitor for symptoms Notify School Nurse Otherwise, call parent **Symptoms:** □ Severe pain □ Aura/ Numbness/ Tingling/Visual Disturbances □ Nausea with or without vomiting □ Other_____ **Triggers:** □ Missing a meal or particular foods □ Weather Changes □ Exertion □ Lack of sleep □ Stress □ Odors □ Loud/continuous noises	Restrictions for Physical Education □ No □ Yes If yes, please specify:
FIELD TRIPS:	**BUS TRANSPORTATION:**
Requires assistance: □ Unlicensed Medication Assistant □ Nurse, if indicated □ None □ Parent/Guardian attending If yes, please specify:	Special arrangements □ No □ Yes If yes, please specify:
EMERGENCY DRILLS / SCHOOL CRISIS	**OTHER:**
□ During Crisis Event Follow School Safety Plan. □ In event of building evacuation, School Nurse or Medication Assistant will evacuate with medications. □ In event of building evacuation, School Nurse Location is: □ Student requires assistance to evacuate building? □ No □ Yes, describe _____	After School Care: Extracurricular Activity:

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Written Notes/Addendum to Plan of Care

DATE		PARENT/ GUARDIAN INTIALS (if needed)

I understand and agree with this Individualized Healthcare Plan.

I give permission for my child to be transported to the hospital indicated on this form, in the event of an emergency.

I give permission for the release of my child's medical information, in the event of an emergency.

Signature of Parent or Guardian **Date**

Signature of School Nurse **Date**

Individualized Health Care Plan **Student Name:** **School Year:**

Communication of the Individualized Health Care Plan

SECTION IV:

☐ Check this Box if Read Receipt is used to communicate Individualized Health Care Plan to staff.
* Nurse to attach Read Receipt document to this packet.

☐ Check this box if staff receives and signs below for Individualized Health Care Plan.

I have read and understand this student's Individualized Healthcare Plan, and have printed a copy to be maintained in my confidential folder/binder of instructions for substitute teachers.

I have been given the opportunity to ask questions.

I understand my role in addressing this students medical needs.

I am aware the school nurse is available to help clarify any future concerns.

Employee Name	Employee Signature	Position Held	Date