Merrill Area Public Schools
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* Student Achievement * Community Partnership * Future Success *

MIGRAINE ACTION PLAN
School Year: 2023-2024

Student's Name: _____ **Date of Birth:** _____

School: _____ **Grade:** _____ **Teacher:** _____

List Triggers: _____

List Symptoms and Frequency: _____

Symptoms are tolerable when pain level is 1-10 with 10 being the worst pain imaginable: _____

Medical Alert - Migraine Treatment Plan
Check all that apply

- ☐ **Contact parent / guardian prior to medicating**
- ☐ **Give medication**
- ☐ **My student should return to class after taking medication**
- ☐ **My student needs to sleep or rest in a dark, quiet area for up to 45 minutes after taking medication**
- ☐ **My student can return to class when pain level is _____ (1-10 with 10 being the worst pain imaginable)**
- ☐ **My student may self-carry migraine rescue medication (Grades 8-12 only)**

Rescue Medication Orders

Medication	Dosage	Time/Frequency

Effective Date: From: _____ **To:** _____

Provider Comments: _____

_____

I give permission for school personnel to administer the above listed medication(s) as ordered to my student for the duration of the current school year. I give permission to share this information with staff on a need to know basis. ***(Signatures required for medication to be administered at school.)***

Parent / Guardian Signature: _____ **Date:** _____

Parent / Guardian Address: _____ **Phone Number:** _____

Physician Signature: _____ **Date:** _____

Physician Address: _____ **Phone Number:** _____