

Information for Teachers

My child, _____, has been diagnosed with Migraine disease. Migraine is a genetic neurological disease characterized by episodes or attacks with multiple possible symptoms. During a Migraine attack, my child may experience:

- | | |
|---|---|
| <input type="checkbox"/> moderate to severe head pain | <input type="checkbox"/> nausea and/or vomiting |
| <input type="checkbox"/> sensitivity to light | <input type="checkbox"/> sensitivity to sound |
| <input type="checkbox"/> visual distortions | <input type="checkbox"/> dizziness |
| <input type="checkbox"/> aphasia | <input type="checkbox"/> nausea and/or vomiting |
| <input type="checkbox"/> mood changes | <input type="checkbox"/> tiredness/sleepiness |
| <input type="checkbox"/> other: _____ | |

When my child experiences a Migraine attack, it is important that he/she take medication as soon as possible. Please allow him/her to go to the nurse's office for medication and to lie down when a Migraine attack strikes, with assistance if necessary.

If you wish to speak with me about my child's health, you can reach me by telephone at _____.

To verify this information for you, my child's physician has also signed below.

Thank you!

Parent's Signature

Date

Parent's Name (Printed)

Phone Number

Physician's Signature

Date

Physician's Name (Printed)

Phone Number

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For information about Migraine disease and other headache disorders, visit www.HelpForHeadaches.com and www.MyMigraineConnection.com.

Information for School Nurse

My child, _____, has been diagnosed with Migraine disease. During a Migraine attack, my child may experience:

- | | |
|---|---|
| <input type="checkbox"/> moderate to severe head pain | <input type="checkbox"/> nausea and/or vomiting |
| <input type="checkbox"/> sensitivity to light | <input type="checkbox"/> sensitivity to sound |
| <input type="checkbox"/> visual distortions | <input type="checkbox"/> dizziness |
| <input type="checkbox"/> aphasia | <input type="checkbox"/> nausea and/or vomiting |
| <input type="checkbox"/> mood changes | <input type="checkbox"/> tiredness/sleepiness |
| <input type="checkbox"/> other: _____ | |

When my child experiences a Migraine attack, it is important that he/she take medication as soon as possible. The following medication(s) have been prescribed by my child's physician to be taken when he/she has a Migraine attack:

Name of medication: _____

Dosage/directions: _____

Name of medication: _____

Dosage/directions: _____

Please contact me if...

- my child reports symptoms that are unusual for him/her or are extreme.
- my child's medication does not provide relief within two hours.
- my child's Migraines seem to be increasing in frequency or severity.
- you need more of my child's medications.
- you wish to discuss anything related to my child's health.

To verify this information for you, my child's physician has also signed below. Thank you!

Parent's Signature

Date

Parent's Name (Printed)

Phone Number

Physician's Signature

Date

Physician's Name (Printed)

Phone Number