Migraine Action Plan For School

(To be completed by health care provider and parent)
2025-2026 School Year

Student Name: _____ **Grade:** _____
Date of Birth : _____ **Teacher:** _____

Migraine triggers:
_____
_____

Daily medications:
_____

1. Safe Zone :	1. Action :
Child has any of these: ● No visible signs of pain ● No additional warning signs ● Denies pain/other symptoms ● Can work / play	☐ Avoid Triggers ☐ Allow desktop fluids and encourage fluid intake ☐ Allow extra bathroom breaks as needed

2. Caution Zone :	2. Action :
Child has any of these: ● Complains of head pain ● Complains of early migraine symptoms: _____ ● Difficulty with work / play	☐ Administer medication(s)- contact parent if administered _____ _____ ☐ Encourage student to drink _____oz of water /sports drink / soda ☐ Allow student to rest in health office ☐ _____ _____

3. Danger Zone :	3. Action :
Child has any of these: ● Medication not helping. ● Vomiting	☐ Call parent for pick up

Health Care Provider (Please print) : _____ Phone # : _____
Signature : _____ Fax # : _____

Parent/ Guardian Signature : _____ Date : _____
Cell Phone # : _____