MIGRAINE HEADACHE

WASHINGTON COUNTY DEPARTMENT OF EDUCATION
COORDINATED SCHOOL HEALTH

University School
Phone (423) 439-8674 Fax (423) 439-5921

Student_____ Date of Birth_____ Teacher_____
Grade_____

It has been noted on your child's information form that (s)he has a diagnosis of Migraine Headaches. It is important to have current health information and direction if (s)he needs assistance at school.

Are medications needed to control this health problem at school: ____No ____Yes (list below)

Medications	Dosage	Time

SPECIAL INSTRUCTIONS NEEDED AT SCHOOL:

_____
_____

_____
_____

_____
_____

_____
_____

_____
_____

This Individualized Health Plan will be shared with trained personnel and Coordinated School Health Staff. It is the parent's responsibility to share this information with other staff you deem necessary (i.e. teachers, coaches, etc.). Your signature below indicates your understanding and agreement with this policy.

Physician Name: _____ Phone:
_____

Physician Signature: _____ Date: _____

Parent Signature: _____ Date: _____

Parent contact: _____
Phone:_____