***Student Health Services***

**Student \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School year \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**To be completed by parent/guardian:**

Please list the triggers/causes of severe headache/migraine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often does your child have headaches/Migraines? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What usually helps with headache/Migraine? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List medications/treatments that have been ordered: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Medication Authorization Form on file)*

|  |  |
| --- | --- |
| **If you see this…** | **Do this** |
| Complains of headache/Migraine | 1. Allow student to receive medication, if ordered by healthcare provider.   Location of Med:  Health Room   Others: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   1. Call parent to bring medication if no medication is available at school. 2. Rest head on desk for 15-20 minutes 3. Cool compress to forehead. |
| Bright light can cause headache to worsen | 1. Allow to rest in dimly lit room, if feasible, for 30 min. 2. If no improvement in one hour, call parent |
| Nausea and/or vomiting | 1. Call parent if vomiting occurs 2. Do not give any medication if vomiting |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature Phone# Date

***Emergency Contact in the event parent cannot be reached:*** Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FOR SCHOOL USE ONLY**

School Nurse Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

** Plan reviewed with \_\_\_\_\_\_\_\_\_\_\_\_\_, teachers \_\_\_\_\_\_\_\_\_,TA \_\_\_\_\_\_\_\_, bus driver\_\_\_\_\_\_\_ Special area teachers, \_\_\_\_\_\_\_\_\_\_\_\_\_ First Responders**

**Parental Permission and Release of Medical Information:**

* As parent/guardian of above student, I consent for the employees of Huntingdon Area School District to follow the plan and use the designated medications on my child in accordance with the instructions above.
* I understand that I am to provide the school with medication and signed authorization form, supplies, etc. to follow the plan.
* I understand that this plan will be shared to all those who need to know (all student’s teachers/office personnel/ bus driver/ emergency responder, etc) unless written objection is stated on this form
* I hereby acknowledge that I have read, understand, and support the Emergency Health Plan.

**Release of Medical Information**

* I hereby authorize my child’s health care provider to release to the school nurse, principal, or other authorized school personnel, specific confidential medical information contained in my child’s record regarding his/her medical condition. Only school staff delivering health care services to my child in school will use this information.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Signature Date