River Valley School District
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HEADACHE HEALTH PLAN

Student Name:	DOB:
	Grade/School
Parent/Guardian Name:	Phone #:
Parent/Guardian Name:	Phone #:
Other Emergency Contact aware of child's condition:	Phone #:
Physician Name:	Phone #:

Signs/Symptoms to watch for:

Headache: ____

Nausea: ____

Vomiting: ____

Sensitivity to light: ____

Aura: ____

Intervention:

Drink Water: ____

Rest 20 minutes (in dark room if possible): ____

Bland snack (like saltine crackers): ____

Ice Pack: ____

Wet paper towels over eyes - warm / cold

Put on glasses: ____

Name of Med: _____

Dose of Med: _____

Side effects of med that you expect:

_____

_____

Known triggers (circle those that apply): Flashing light, hormone changes, caffeine intake or lack of, odors, weather changes, consumption of processed food, lack of sleep, seasonal allergies

Medication will be kept in the office and a medication request/consent form is completed and on file.

Next steps: If the interventions above do not begin to resolve the headaches, please do the following:

_____

_____

Parent Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____