



Carroll ISD Health Services
Parental Authorization for Migraine Action Plan 2020-2021

Parent please answer:	
Special Ed services?	yes / no
Active 504 plan?	yes / no
I would like 504 information	yes / no

Name: _____ D.O.B.: _____ Grade/Teacher: _____
 Parent/Guardian: _____ Phone: _____
 Parent/Guardian: _____ Phone: _____
 Transportation: Car rider Walker Drives self Rides bus # _____
 Before/After school activities: Athletics Band Club: _____ Tutoring Other _____

Diagnosis/Significant medical history: _____

Allergies: _____

Non-Pharmacological treatments:
Frequency, severity, and duration of attacks:
Presenting or typical signs and symptoms:
Triggers/ precipitating factors:
Restrictions:
Additional assessment information:
Can student identify signs and symptoms of an impending migraine? <input type="radio"/>yes <input type="radio"/>no <input type="radio"/>sometimes
Can student appropriately select treatment based on severity of migraine? <input type="radio"/>yes <input type="radio"/>no <input type="radio"/>sometimes
Current Medications to migraines/ headaches: _____ Keep in Clinic? <input type="radio"/> yes <input type="radio"/> no
Does student have nutrition and/ or fluid management needs? Please describe:

I grant permission to Carroll ISD to follow the above plan for my child. I am giving permission to CISD to contact my physician for additional information as necessary. If the school nurse deems necessary, I grant permission to notify my student's teacher of his/her health plan.

Physician- Print Name:	Physician Phone:
Parent/ Guardian Signature:	Parent/ Guardian Phone: