



**SCHOOL INFORMATION SHEET
FOR
STUDENTS SUFFERING FROM HEADACHES**

Student Name: _____

School: _____

School Phone No. _____

Name of contact person / school nurse: _____

Diagnosis: Migraine Tension Type Daily Headache Other _____

MEDICATIONS USED:

Preventive Medication(s): _____

Acute Medications:

For nausea _____ Possible side effects _____

For headache pain _____ Possible side effects _____

_____ Possible side effects _____

Rescue medication _____ Possible side effects _____

Non-drug Measures:

- Ice pack to head
- Acupressure techniques (information available upon request)
- Dark quiet room

Please contact our office if the student is missing an excessive amount of school time, or if you have any further questions.

Your doctor: _____

Office phone number: _____