SUMTER COUNTY SCHOOLS - SCHOOL HEALTH SERVICES
MIGRAINES/HEADACHES PARENT INTERVIEW GUIDE

Please complete this form with as much accurate information as possible. The information provided is used to develop an individualized health care plan for your child to promote a safe environment with a goal to maintain optimal health. Important: Include correct numbers where you can be reached.

Student's Name: _____ Date of Birth: _____
Student's Address: _____
Age: _____ Grade: _____ Teacher: _____ School: _____
Parent/Guardian: _____ Phone #1: _____
_____ Phone #2: _____
Emergency Contacts: _____ Phone #1: _____
_____ Phone #2: _____
Treating Physician: _____
Phone: _____ Fax: _____
Preferred Hospital: _____ Allergies: _____

1. Medical diagnosis: _____
2. Are there any known triggers that contribute to the onset of a migraine/headache for your child?

_____

3. What are his/her usual signs and symptoms? *(Check all that apply)*

☐ Pain in the face/head/neck ☐ Light sensitivity ☐ Dizziness ☐ Lightheadedness
☐ Sensitivity to sound ☐ Changes in vision ☐ Irritability ☐ Fainting ☐ Stuffy nose
☐ Nasal drainage ☐ Nausea/Vomiting ☐ Watery eyes ☐ Other _____

4. Is there anything that helps to improve symptoms during episodes? (example: turn lights off or down)

_____

5. What medication(s) does your child take at home? _____

_____

6. What medication(s) does your child take at school and when? _____

_____

7. Any special instructions including needs for special health requirements in the classroom or at school?

_____

_____

As parent/guardian by signing this form, I give permission for Sumter County Schools to share this information with the faculty and staff who are directly involved in my child's education and/or school health services.

_____ _____ _____
Parent signature Please Print name Date