



UNIVERSITY SCHOOL

EAST TENNESSEE STATE UNIVERSITY

68 Martha Culp Drive, Johnson City, TN 37614

Phone (423) 439-8674 Fax (423) 439-5921

MIGRAINE HEADACHE IHP

Student _____ Date of Birth _____ Grade _____

It has been noted on your child's information form that (s)he has a diagnosis of Migraine Headaches. It is important to have current health information and direction if (s)he needs assistance at school.

Frequency of headaches? _____

Are medications needed to control this health problem at school: ___ No ___ Yes

Medications	Dosage	Time

SPECIAL INSTRUCTIONS NEEDED AT SCHOOL:

The parent signature below gives permission for the school nurse or representative to fax this form to the indicated PCP and to communicate with said PCP, the PCP's office staff, and the ETSU University School faculty/staff regarding this health plan for the student named above, and their care. It is the parent's responsibility to share this information with other staff you deem necessary (i.e. teachers, coaches, etc.). Your signature below indicates your understanding and agreement with this policy.

Physician Name: _____ Phone: _____

Physician Signature: _____ Date: _____

Parent Signature: _____ Date: _____

Parent contact: _____ Phone: _____