Tempe Union High School District
Request for Medical Documentation – Migraines

Student's Name:
Student ID:

Date:

Dear Parent/Guardian,

Attached are forms for your student for the upcoming school year. New forms are required each school year. The forms attached are:

1. Migraine History Form to be filled out by parent
2. Consent for Medication Administration Form, to be filled out by the parent and/or the licensed health care provider.

Please complete the Consent for Medication Administration form if your student requires over the counter or prescription medication during the school day.

If you would like to request a meeting with the nurse regarding your student's health care needs, please let me know and I will arrange a meeting.

Feel free to contact your school health office with any questions.

Thank you,

Tempe Union High School District
MIGRAINE DISORDER HISTORY

Instructions: Complete and return form to the school health office

Student Name _____ DOB _____
ID Number _____ Date _____

1. What type of migraine does your student have? Please describe your student's typical migraine.

_____

2. How often do migraines occur? How long do the migraines normally last?

_____

3. When was your student's last migraine?

_____

4. Is there anything that seems to trigger a migraine? ☐ No ☐ Yes If yes, explain.

_____

5. Does your student experience an aura before a migraine? ☐ No ☐ Yes If yes, explain.

_____

6. How are your student's migraines treated (daily medication, rescue medication)?

_____

7. Is your student currently taking medication to control their migrianes? ☐ No ☐ Yes If yes, list name, dosage, and how often your student takes this medication. **If the medication is to be kept in the health office, Consent for Medication form must be on file.**

_____

Parent/Guardian Signature: _____ Date: _____

TEMPE UNION HIGH SCHOOL DISTRICT
Consent for Giving Prescription and Non-Prescription Medications at School
School Year _____ to _____

Student Name _____

School _____ **Student ID** _____

Medication must be delivered to school in the original container with the label intact.

The medication is to be given in the following manner:

Name of Medication: _____

Strength of Medication: _____

Amount to be Given: _____

Time of Administration at School: _____

Route of Administration (by mouth, etc.):_____

Comments and/or Instructions: _____

Reason for Medication: _____

Date Medication is to be discontinued: _____

☐ Student may self-carry and self-administer their medication (**Valid only for diabetes, asthma, and anaphylactic reactions. Students may not carry any other medications.**)

Healthcare Provider Name: _____ **Phone No.** _____
(Please print)

_____
Healthcare Provider Signature **Date**

I hereby request and my consent for the School Nurse or person designated by the School Administration to give my child medication prescribed by the below listed licensed health care provider. **I acknowledge that it may be necessary for the assistance in administration of medication to my child to be performed by an individual other than a nurse, and specifically consent to such practice.**

I understand the law provides that there shall be no liability for civil damages as a result of the assistance in administration of such medication and/or treatment where the person assisting in the administration of such medication and/or treatment acts as an ordinarily reasonably prudent person would under the same or similar circumstances. I understand my child's medication is to be presented to a school representative by an adult. I will assume full responsibility for the supply, appropriate transportation and maintenance of above medication. If any changes in medication or dosage occur, the school must be notified immediately, and a new form must be completed. I give permission for the exchange of information directly with the healthcare provider regarding my child's medication. **Any medications not picked up by the last day of school by the student's parent/guardian, or other designated adult, will be destroyed.**

_____
Parent/Guardian Home Phone # **Parent/Guardian Work Phone #**

_____
Parent/Guardian Signature **Date**