



WATCHUNG HILLS REGIONAL HIGH SCHOOL

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SUPERINTENDENT

TIMOTHY M. STYS, CPA
BUSINESS ADMINISTRATOR

WILLIAM J. LIBRERA
PRINCIPAL

Dear Parent/Guardian,

You have indicated in school records that your child has an ongoing health need that may require medication and/or treatment during the school day. Please see your physician to have the appropriate action plan completed and signed and submit it to the health office prior to the first day of school.

New Jersey State Law requires your healthcare provider's written order and parent/guardian authorization for a nurse to administer medications. Medications must be in pharmacy –prepared containers and labeled with the name of the student, name of the drug, strength, dosage, frequency, name of physician, date of original prescription. In the event of an emergency other staff may need to care for your child until medical personnel arrives. Please read and sign below if you agree to share medical information with WHRHS staff for your child.

I give permission to the school nurse, trained personnel, and other designated staff members of Watchung Hills Regional High School to perform and carry out the necessary care tasks as outlined by N.J.S.A 18A:40-12.11-21, referring to the administration of Glucagon, and N.J.S.A.18A:40-12.5 for the administration of epinephrine via a pre-filled auto-injector mechanism. I also consent to the release of information contained in this Medical Management Plan to all staff members and other adults who have custodial care of my child during the school day and during school sponsored events who may need to know this information to maintain my child's health and safety.

Please send/bring completed forms and any medications or equipment to the Health office prior to or on the first day of school. This information enables the healthcare team at WHRHS to provide optimal care to your child in the event of an emergency. Your immediate attention to these matters is greatly appreciated. If you have any further questions please do not hesitate to contact the nurses at 908-647-4800.

Thank You

The School Nurses

Acknowledged and Received by:

Student's Parent/Guardian

Date _____



Migraine/Headache Care Plan

Student Name: _____ **Date:** _____

Headache symptoms account for many visits to the health room and phone calls to parents. Many of these headaches are painful, but do not constitute a serious problem.

Tension headaches are usually caused by stress or poor posture. Scalp and neck pain, or a feeling of a “tight band” around the head characterizes them.

The classic migraine headache is characterized by an aura, or warning of an attack, such as numbness of the face or arm, tingling sensations, or vision changes. Following this, pain occurs frequently on one side of the head. The student may find light makes the headache worse. The exact cause of this type of headache is unknown, but appears to be due to chemical changes that make the blood vessels in the brain constrict and dilate. Triggers can include: stress, fatigue, overwork, the menstrual cycle, and dietary intake of such things as caffeinated drinks, chocolate, cheese.

Problem: Pain (Migraine Headaches)

Goal: Relieve discomfort.

Action:

1. Administer medication, _____, as prescribed: *(Insert instructions.)*
 - a. This medication, if given during the aura, may prevent or decrease the symptoms of pain.
 - b. Side effects that must be reported to parent and school nurse include: *(Insert effects.)*
2. Allow (_____) to rest in health office.
 - a. If there is no improvement, or headache becomes worse, contact parent.
3. Note headache, including symptoms, length of symptoms, when it occurred, what the student was doing that might have precipitated the headache, and action taken will be documented.

Physician Signature Date

Parent/Guardian Signature Date

School Nurse Signature Date