VNS (VAGUS NERVE STIMULATOR)
PERMISSION AND INSTRUCTION
HEALTH SERVICES
SCHOOL DISTRICT U-46

School Year: _____
Student Name : _____ Date of Birth _____

Grade: _____ Teacher:_____ School:_____
I give my permission for the use of a VNS magnet for the above named student at school for the treatment of seizures. I give my permission for the school nurse to communicate with the physician as needed with regard to my student's seizures and use of the VNS magnet. I will notify the nurse of any changes in my student's health condition. I will provide the necessary supplies.
Parent Signature:_____ Date:_____
Home phone:_____ Work phone:_____ Cell phone:_____

PHYSICIAN INSTRUCTIONS:

Medical Diagnosis:_____

1. **Confirm the location of the VNS:**
   Left upper quadrant of chest: _____
   Other Location-describe:_____

2. **Please indicate which of the following directions are to be followed:**
   Swipe magnet at onset of seizure
   Magnet is to be swiped no more than _____ inches from the body

   _____Standard Protocol
   If seizure continues after one (1) minute of first swipe, may repeat one (1) swipe of the magnet every minute for up to three (3) additional swipes.

   OR

   _____Individualized Protocol
   If seizure continues after _____ minute(s) of first swipe, may repeat _____ swipe(s) of magnet every minute for up to _____ additional swipes.

If seizure does not stop with swipe(s) of VNS magnet within _____ minutes, administer Emergency Medication per orders and Call 911.

Additional Information:_____
_____

Signature: _____ Date of signature:_____
Signature of Physician — Month Day Year

Physician's Printed Name: _____
Physician's printed name — Medical Group/Clinic

Office Address: _____
Street Address — Suite # if necessary — City — ZIP

Office Phone: _____ Fax Number:_____
area code + number — area code + number