revised August 2021

ALABAMA STATE DEPARTMENT OF EDUCATION

SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION
FOR VAGUS NERVE STIMULATOR (VNS)

School Year: _____-_____

STUDENT INFORMATION

Student's Name _____ School: _____

Date of Birth: _____/_____/_____ Grade _____ Teacher _____

☐ Known drug allergies/reactions If drug allergies, list: _____ Weight: _____ pounds

PRESCRIBER AUTHORIZATION

(To be completed by licensed healthcare provider)

START DATE: _____ STOP DATE: _____

Procedure: Swiping magnet over student's VNS

Reason for procedure: To shorten duration of, or stop, seizure activity.

How& frequency r/t swipe delivery: Swipe magnet over VNS for full 1-2 second time period, at onset of seizure activity.

Repeat swipe X _____ if seizure activity does not cease after _____ minute(s).

If magnet is held in place over the VNS for longer than 60 seconds at one time, the generator will be turned off until the magnet is removed. Once magnet is removed, the device will resume its normal cycle.

Do you recommend the magnet be kept "on person" by the student? □ Yes □ No
If "no", storage location of magnet will be identified in student's Individualized Healthcare Plan.

Potential Contradictions/Adverse Reactions: _____

ALL ORDERS ARE GOOD FOR ONE CALEDER YEAR UNLESS OTHERWISE NOTED WITH "STOP DATE"

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_____ Printed Name of Licensed Healthcare Provider

_____ _____ _____ _____

Signature of Licensed Healthcare Provider Date Phone Fax

PARENT AUTHORIZATION

I authorize the School Nurse, the registered nurse (RN) or licensed practical nurse (LPN) to assist my child in the above procedure, and to delegate to trained, unlicensed school personnel, the task of assisting my child with the above prescribed procedure, in accordance with administrative code practice rules. I understand that additional parent/prescriber signed statements will be necessary if the procedure is changed. I also authorize the School Nurse to talk with the licensed healthcare provider should a question come up about the procedure.

Procedure equipment or supplies must be registered with the school nurse or his/her designee.

_____ _____ _____ _____

Signature of Parent Date Phone Cell