children's health

Neurology Department

Physician/Parent Authorization for Vagal Nerve Stimulation Care

214-456-2768

Student: _____ DOB: _____

Parent(s) Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

School: _____ Grade: _____

TO BE COMPLETED BY THE MEDICAL PHYSICIAN:

This student has been referred for consideration for continuation of Health Services. Nursing services are provided to students with disabilities who must have these services in order to benefit from instruction. The following is based on the medical records at Children's Health and the physician's knowledge of the student.

Diagnosis or description of disability/special health need: _____

Medications (include antiepileptic): _____

Date VNS was implanted: _____

List of procedures performed: _____

Special instructions regarding this procedure (Please attach facility protocol, if applicable): _____

_____

Type of magnet: Watch-style: _____ Paper-style: _____

What is the frequency of use during the school day (ex. once every hour?) _____

Side effects and interventions should side effect occur: _____

_____

Special instructions on utilizing the magnet:

- ☐ Move magnet in a cross formation over the Pulse Generator
- ☐ Position the magnet on the Pulse Generator for a total of _____ second(s) or
- ☐ Other directions: _____

Instruction for stopping the Pulse Generator: Under what conditions should the magnet be attached to the Pulse Generator to stop stimulation? _____

What type of equipment should the parent provide in order for this procedure to be performed? _____

_____

Physician's Signature: _____ Date: _____

Physician's Name: _____ Phone: _____ Fax: _____

Address: _____

City: _____ State: _____ Zip Code: _____

We (I) the undersigned, the parent(s)/guardian(s) of _____ request the above medication or procedure to be administered to our (my) child. We (I) authorize, as needed, the sharing of information related to my child's health between the school nurse (or designee) and the health care provider listed above.

_____ / _____ Telephone _____ / _____

Name Relationship Home/Cell Business

_____ / _____ Telephone _____ / _____

Name Relationship Home/Cell Business

Note: This prescription with be valid for one year pending changes in the student's medical condition (i.e. surgical intervention, etc.)