Chino Valley Unified School District

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PARENT AND PHYSICIAN/HCP REQUEST FOR USE OF VAGUS NERVE STIMULATOR AT SCHOOL AND SCHOOL ACTIVITIES

Student: _____ DOB: _____ Grade: _____

Address: _____ Home Telephone: _____

School Site: _____ School Fax: **(909)**_____ **Attn: Health Office**

PARENT REQUEST/CONSENT FOR USE OF VAGUS NERVE STIMULATOR AT SCHOOL AND SCHOOL ACTIVITIES

I (we) the undersigned, the parent(s)/guardian(s) of the above-named student, request the specialized physical health- care service be administered to my (our) child in accordance with state laws and regulations. I (we) will: 1. provide the necessary supplies and equipment; 2. notify the credentialed school nurse if there is a change in child's health status or attending authorized health-care provider; and 3. notify the credentialed school nurse immediately and provide new written consent/authorization for any changes in the above authorization. I (we) give consent for the credentialed school nurse to communicate with the authorized health-care provider when necessary. I (we) understand I (we) will be provided a copy of my child's completed Individualized Health-Care Plan (IHP). The fact that this is a service or accommodation is recognized by all parties signing this form, and in so signing, agree to hold the District, its officers, employees, or agents harmless from all liability, suits, or claims of whatever nature or kind that might arise out of these arrangements.

Parent/Guardian Signature: _____ **Date:** _____

REQUEST FOR PHYSICIAN/HEALTH CARE PROVIDER USE OF VAGUS NERVE STIMULATOR AT SCHOOL AND SCHOOL ACTIVITIES

1. Is the Student able to self-treat? □ Yes □ No
2. Initiate VNS magnet □ At onset of aura □ At start of seizure □ Other
3. Swipe magnet over VNS device for _____seconds and observe pupil for further seizure activity.
4. If seizure activity continues, repeat swipe every _____seconds for _____minutes.
5. Continue to use VNS until seizure stops or EMS arrives or until _____.
6. If student continues to have seizure longer than _____minutes and/or _____
   □ Call 911
   □ Administer emergency anti-seizure medication (please fill out the Medication Administration form)
7. Does the student have any activity restrictions: _____
8. List possible negative reactions and recommended interventions: _____
   _____
9. List any concerns about transporting the student on the bus: _____

My signature below provides authorization for the above written orders. I understand all procedures will be implemented in accordance with state laws and regulations. _____ (Initial here) I authorize unlicensed designated school personnel, under the training and supervision provided by the credentialed school nurse, may provide this procedure. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization. Authorizations may be faxed.

Physician's/HCP Name (Printed) _____
Physician/HCP Signature _____
Date _____
Address _____
Telephone _____
Fax _____

Physician/HCP Office Stamp

FOR SCHOOL USE ONLY:

Date	Medication/Supplies Exp Date	Amount Rec'd (count together)	Signature of Parent/Guardian	Signature of Receiver

Medication procedures, parent authorization, and physician's HCP order(s) for medication(s) have been verified by the School Nurse or Principal.
*If not brought in by parent, verify receipt and amount with parent by telephone