LIVINGSTON PARISH PUBLIC SCHOOLS

VAGAL NERVE STIMULATOR (VNS)

PHYSICIAN'S ORDER

(This form is valid **only** for the current school year, including summer school.)

Student's Name_____

Date of Birth_____

Medical Diagnosis_____

Check All That Apply

_____Swipe magnet at onset of seizure

Location of VNS: _____left upper quadrant of chest

_____other_____

_____If seizure continues after one (1) minute of first swipe, may repeat one (1) swipe of magnet every minute for up to _____additional swipes.

_____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 the swipe of VNS magnet within five (5) minutes, Call 911.

After VNS is used:

_____The student may stay in class if back to baseline neurological status.

Physician Signature: _____ Date: _____

Physician Name_____

Phone: _____ Fax: _____

Stamp: