PRESCRIPTION FOR PROTECTIVE AND STABILIZING DEVICE

Health Center – School Year 2024-25

**This form must be signed by a Health Professional. Additional documentation may be attached as necessary.**

Student's Name: Click or tap here to enter text.

Date of Birth: Click or tap to enter a date.

Name of Device: Click or tap here to enter text.

# **Purpose of Device**: (Please check one)

[ ]  To ensure student's safe positioning

[ ]  To ensure positioning that enhances student's functional skills

[ ]  To protect student from self-injury (Please describe below)

Click or tap here to enter text.

# **Prescription**: (Please answer all questions)

When is the device to be used? Click or tap here to enter text.

How long can the device be left on the student? Click or tap here to enter text.

How often should breaks from the device be taken? Click or tap here to enter text.

How long does each break need to be? Click or tap here to enter text.

What risks are there from use of the device? Click or tap here to enter text.

# **Expiration of Prescription**: (To continue use of the device in school, and new order will be necessary upon expiration of this order or at the beginning of each school year – whichever is sooner)

When does this prescription expire? (Enter complete date) Click or tap to enter a date.

Prescribing Provider's Name and Credentials: Click or tap here to enter text.

Prescribing Provider's Phone Number: Click or tap here to enter text.

Prescribing Provider's Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: Click or tap to enter a date.

PB/LB/cic:4/23/24