



**The Maryland School for the Blind**  
3501 TAYLOR AVENUE BALTIMORE, MARYLAND 21236 410-444-5000

**PRESCRIPTION FOR PROTECTIVE AND STABILIZING DEVICE**

**Health Center - School Year 2026-2027**

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

Name of Student: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Device: \_\_\_\_\_

**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)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

When is the device to be used? \_\_\_\_\_  
\_\_\_\_\_

How long can the device be left on the student? \_\_\_\_\_

How often should breaks from the device be taken? \_\_\_\_\_

How long does each break need to be? \_\_\_\_\_

What risks are there from use of the device? \_\_\_\_\_

**Expiration of Prescription: (To continue use of the device in school, a 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) \_\_\_\_\_  
(month, date, year)

**Prescribing Provider's Name and Credentials:** \_\_\_\_\_

**Prescribing Provider's Phone Number:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

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**SIGNATURE of Prescribing Provider**

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**DATE**

PB/cic:5/14/25