Does this student have? [ ] Individualized Education Program (IEP)  [ ] Section 504 Plan (please notify IIS office when IIS IEP is complete).

Date application given to parent/guardian ____/____/______ Date application returned from parent/guardian ____/____/______

Date school submitted application to IIS Office ____/____/______

I understand that after 30 days of beginning IIS, the student’s counselor and/or school team will develop a return to school plan as appropriate.

Counselor/Principal/Designee Signature _____________________________ Date ____/____/______

COUNSELOR/PRINCIPAL/DESIGNEE SHOULD SCAN AND E-MAIL THE COMPLETED APPLICATION TO IISOFFICE@MCPSMD.ORG
MEDICAL VERIFICATION
For Physical Health Conditions Only
To be completed by the Physician/Certified Nurse Practitioner

Dear Physician or Certified Nurse Practitioner (CNP):

Before processing a request for Interim Instructional Services (IIS), a verification made within 30 days of this application of the student’s physical health condition from a physician or CNP is required. Service need must be reviewed every 60 calendar days after the initial date of verification or sooner at the request of the parent/guardian or MCPS.

Please provide the following information (this information may be attached to this signed document):

1. Specify the physical health condition that prevents the student from attending their school of enrollment. If the request is due to pregnancy, list the expected date of delivery.

________________________________________________________________________________________________________________
________________________________________________________________________________________________________________

2. Reasons the condition prevents the student from attending school.

________________________________________________________________________________________________________________
________________________________________________________________________________________________________________

3. Date of most recent appointment ____/____/_____

4. Is this condition contagious?  □ Yes □ No  Describe ____________________________________________________________________________

5. Is the student currently taking any medication?  □ Yes □ No

Medicine/Dosage ____________________________________________________________________________

6. Describe the specific strategies that you, as the referring professional, will implement to assist the student’s return to school (transition plan).

________________________________________________________________________________________________________________
________________________________________________________________________________________________________________

7. Requested duration of services (no more than 60 days)_________________

8. Recommendations for school attendance:

□ Student is unable to attend school

□ Student is able to attend regular day program and student’s school of enrollment with modifications

□ Student is able to attend school part-time  □ AM □ PM

9. □ If checked, this student cannot access instruction virtually. Please provide details explaining why.

________________________________________________________________________________________________________________
________________________________________________________________________________________________________________
________________________________________________________________________________________________________________
________________________________________________________________________________________________________________

I certify that:

□ I am a licensed physician or certified nurse practitioner and am currently treating this student.

□ This student IS NOT able to attend the regular day program at their school of enrollment because of their physical health condition.

Signature of Physician/CNP ______________________________________________________________ Date ____/____/_____

Printed Physician/CNP Name ___________________________ License Number ___________________________

Address ___________________________________________________________ Phone ____-____-______