Maryland's Largest School District

MONTGOMERY COUNTY PUBLIC SCHOOLS

በጊዜያዊነት ለሚሰጥ የትምህርት አገልግሎት ማመልከቻ፣ አካላዊ የጤንነት ሁኔታ መስፈርት ለሚያሟላ/ለምታሟላ ብቻ

Department of Career Readiness and Innovative Programs
Interim Instructional Services ጊዜያዊ የማስተማር አገልግሎቶች
MONTGOMERY COUNTY PUBLIC SCHOOLS (MCPS) የሞንትጎመሪ ካውንቲ ፐብሊክ ስኩልስ
CESC, Room 248, Rockville, Maryland

ማሳሰቢያ፡- ይህ ቅጽ በጊዜያዊ የትምህርት አገልግሎት (IIS) ጽህፈት ቤት የአካል ጤንነት ችግር ላለባቸው ተማሪዎች ትምህርት ለመስጠት ከሐኪም ወይም የሙያ ፍቃድ ካለው/ካላት ነርስ ባለሙያ ሪኮመንዴሽን ለማግኘት እና ወላጅ/አሳዳጊ ፈቃድ ለማግኘት ጥቅም ላይ ይውላል። የተሞላው ማመልከቻ ለተማሪው(ዋ) የት/ቤት ካውንስለር ወይም ርእሰ መምህር/ተወካይ ይመለስ። የበለጠ መረጃ ለማግኘት የሞንትጎመሪ ካውንቲ ፐብሊክ ስኩልስ ጊዜያዊ የትምህርት አገልግሎቶች ደንብ- MCPS Regulation IOE-RB ይመልከቱ.

ከ60 የካላንደር ቀናት በላይ ቀጣይ አገልግሎት ለማግኘት አዲስ ማመልከቻ መሙላት ያስፈልጋል።

I. በወላጅ/ሞግዚት የሚሞላ እባክዎ ይጻፉ ወይም ታይፕ ያድርጉ።

የተማሪ ስም (የመጨረሻ፣ የመጀመሪያ፣ የመካከለኛ መጀመሪያ ፊደል) _____

የሞንትጎመሪ ካውንቲ ፐብሊክ ስኩልስ መታወቂያ ቁጥር-MCPS ID#_____

MCPS ት/ቤት _____ ክፍል ት/ቤት_____ የተከታተለ(ች)በት የመጨረሻ ቀን_____

በሞንትጎመሪ ካውንቲ ፐብሊክ ስኩልስ (MCPS) ፋይል ላይ ያለው የተማሪው መኖሪያ አድራሻ ትክክል ነው፡- ❑ **አዎ** ❑ **አይደለም (አይደለም ከሆነ፣ የእርስዎን ወቅታዊ አድራሻ ለተማሪዎ የአካባቢ ትምህርት ቤት ማስተካከል አለብዎት)**

የወላጅ/አሳዳጊ ስም (እባክዎን ይጻፉ) _____

ወላጅ/አሳዳጊ የስልክ ቁጥር የቤት _____-_____-_____ **የሥራ** _____-_____-_____ **ኤክስቴንሽን**_____ **ሞባይል** _____-_____-_____

የወላጅ/ሞግዚት ኢ-ሜይል አድራሻ _____

ዝምድና/ግንኙነት ❑ **እናት** ❑ **አባት** ❑ **ሞግዚት** ❑ **ሌላ (በግልጽ ይጻፍ)** _____

የወላጅ/አሳዳጊ ስም (እባክዎን ይጻፉ) _____

ወላጅ/አሳዳጊ የስልክ ቁጥር የቤት _____-_____-_____ **የሥራ** _____-_____-_____ **ኤክስቴንሽን**_____ **ሞባይል** _____-_____-_____

የወላጅ/ሞግዚት ኢ-ሜይል አድራሻ _____

ዝምድና/ግንኙነት ❑ **እናት** ❑ **አባት** ❑ **ሞግዚት** ❑ **ሌላ (በግልጽ ይጻፍ)** _____

እባክዎ ልጅዎ ትምህርት ለመቀበል መገኘት የሚችልባቸውን/የምትችልባቸውን ጊዜያት ምልክት ያድርጉ፡- ❑ **የስራ ቀኖች** ❑ **ምሽቶች** ❑ **እሑድና ቅዳሜ/የሳምንት መጨረሻ**

የምርመራውን ትክክለኛነት ለማረጋገጥ እና/ወይም የሕክምና ውጤቶችን ለማብራራት ልጄን ሲያከም/ስታክም የቆየ(ች)ውን ሐኪም/የተረጋገጠ ነርስ ባለሙያ ለማማከር ለሞንትጎመሪ ካውንቲ ፐብሊክ ስኩልስ (MCPS) የፈቀድኩላቸው መሆኔን አረጋግጣለሁ። የጊዜያዊ ትምህርት አገልግሎት እስከሚረጋገጥ ድረስ የሞንትጎመሪ ካውንቲ ፐብሊክ ስኩልስ (MCPS) አገልግሎት የማስቆም መብት እንዳለው ተገንዝቤአለሁ።

የወላጅ/የሞግዚት ፊርማ _____ **ቀን**____/____/_____

II. በካውንስለር/ርእሰመምህር/በተወካይ የሚሞላ እባክዎ ይጻፉ ወይም ታይፕ ያድርጉ

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

ወላጅ/አሳዳጊ: እባክዎ በዚህ ቅጽ ገጽ 2 ላይ ፈቃድ ያለው/ያላት የተማሪው ኃኪም ወይም ፈቃድ ያለው/ያላት ነርስ ፕራክቲሽነር አማካኝነት ከተሞላ በኋላ ማመልከቻውን በሙሉ ወደ ትምህርት ቤት ያቅርቡ።

Student Name_____

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 _____-_____-_____