臨時教學服務申請(僅限於符合條件的身體健康狀況)

Department of Career Readiness and Innovative Programs
Interim Instructional Services
MONTGOMERY COUNTY PUBLIC SCHOOLS (MCPS)
CESC, Room 248, Rockville, Maryland

說明: 臨時教學服務(IIS)辦公室使用這份表格徵得醫師/註冊職業護理師的推薦和家長/監護人的同意, 以便為有身體健康問題的學生開始提供教學。**請把填妥的申請表交回給學生的輔導員或校長/指定負責人。**欲知更多資訊, 請參見MCPS規章IOE-RB, 臨時教學服務。

必須重新遞交一份填妥的申請才能在60個日曆日以後繼續接受服務。

I. 由家長/監護人填寫。請用正楷填寫或打印。

學生姓名(姓、名、中間名) _____ MCPS ID號碼#_____

MCPS學校 _____ 年級_____ 最後一個上學日 _____

MCPS檔案中保存的學生住址準確無誤: ❑ 是 ❑ 否 (如果回答否, 您必須向學生住家所屬學校提供您的最新住址)

家長/監護人姓名(請用正楷書寫) _____

家長/監護人電話號碼 住家 _____-_____-_____ 工作 _____-_____-_____ 分機_____ 手機 _____-_____-_____

家長/監護人的電子郵件 _____

關係 ❑ 母親 ❑ 父親 ❑ 監護人 ❑ 其他(請說明) _____

家長/監護人姓名(請用正楷書寫) _____

家長/監護人電話號碼 住家 _____-_____-_____ 工作 _____-_____-_____ 分機_____ 手機 _____-_____-_____

家長/監護人的電子郵件 _____

關係 ❑ 母親 ❑ 父親 ❑ 監護人 ❑ 其他(請說明) _____

請勾選您孩子可以接受教學的時間: ❑ 週一至週五 ❑ 晚上 ❑ 週末

我授權蒙郡公立學校(MCPS)諮詢為我孩子治療的醫師/註冊護師, 確認診斷結果並/或說明醫學符號。我知道, MCPS在確認是否有需要提供臨時教學服務之前有權暫不提供服務。

父母/監護人簽名 _____ 日期

II.由輔導員/校長/指定負責人填寫。請用正楷填寫或打印。

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

家長/監護人: 請學生的執業醫師或註冊職業護理師填妥這份表格的第2頁, 然後把整份申請表交給學校。

(見背面)

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 _____-_____-_____