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。
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?  o Yes  o No  Describe ____________________________________________________________

5. Is the student currently taking any medication?  o Yes  o 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:
   o Student is unable to attend school
   o Student is able to attend regular day program and student’s school of enrollment with modifications
   o Student is able to attend school part-time  o AM  o PM

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

I certify that:
   o I am a licensed physician or certified nurse practitioner and am currently treating this student.
   o 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 _____-____-______