I. Does/Will the Student Have a Section 504 Plan? [ ] Yes [ ] No

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
PSYCHIATRIST/PSYCHOLOGIST VERIFICATION
For Mental Health Conditions Only

Dear Mental Health Professional:

Before processing a request for Interim Instructional Services (IIS), a verification made within **30 days** of this application of the student’s emotional condition from a licensed psychiatrist or licensed psychologist 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. Diagnosis (Include DSM-V code): _______________________________________________________________________________

2. Specify why the mental health condition prevents the student from attending their school of enrollment _______________________________________________________________________________
_____________________________________________________________________________________________________________

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

4. How often is the student seen in your office? _______________________________________________________________________

5. Is the student currently in therapy?  
   - Yes  
   - No
   Therapist’s name ________________________________________________
   Phone ____-____-______ Frequency of visits ____________________________________Date of last visit ____/____/_____

6. Is the student currently taking any medication?  
   - Yes  
   - No
   Medicine/Dosage ___________________________________________________________________________________________
   How does the medication impact school performance?
   __________________________________________________________________________________________________________
   __________________________________________________________________________________________________________

7. Explain any precautions to be taken when teaching this student
   __________________________________________________________________________________________________________
   __________________________________________________________________________________________________________

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

9. Requested duration of services **(no more than 60 days)**____________________

10. Recommendations for school attendance:
   - Student is unable to attend school
   - Student is able to attend regular day program and their school of enrollment with modifications
   - Student is able to attend school part-time
     - a.m. or
     - p.m.

11. If checked, this student cannot access instruction virtually. Please provide details explaining why.
   __________________________________________________________________________________________________________
   __________________________________________________________________________________________________________
   __________________________________________________________________________________________________________
   __________________________________________________________________________________________________________

   - I am a **licensed psychiatrist** or **licensed psychologist** and am currently treating this student; or
   - I am a certified school psychologist and am working with the student and the student’s family to identify community resources that can assist with the student’s treatment.

   **AND**
   - This student **IS NOT** able to attend the regular day program at their school of enrollment because of their mental health condition.

   Signature of Psychiatrist/Psychologist _________________________________________________________________Date ____/____/_____

   Printed Name _____________________________________________________________________ License Number_____________________

   Address _______________________________________________________________________________________
   Phone ____-____-______