居家和醫院教學申請(僅限於符合條件的心理健康狀況)

居家和醫院教學
MONTGOMERY COUNTY PUBLIC SCHOOLS (MCPS)
CESC, Room 248, Rockville, Maryland

說明: 居家和醫院教學(HHT)辦公室使用這份表格徵得精神科醫生、心理醫生或心理保健執業護士的推薦和家長/監護人的同意, 以便為有心理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。**請參見MCPS《規章IOE-RB, 居家和醫院教學》, 了解更多信息。

如果要在60個日曆日以後繼續接受服務, 則必須遞交一份新的申請, 其中應包含執業醫師做出的最新診斷和治療信息。

申請人必須填寫和提交這份申請表的所有部分, 我們才會考慮這份申請:

I. 家長應填寫的部分, 包括簽名
II. 學校應填寫的部分
III. 執業醫師的證明, 包括學校可以採取哪些具體步驟來支持學生重返教學
IV. 返校計畫: 應當在提交申請前與所有相關人士就返校計畫展開討論。計畫最好能與申請表一同遞交, 但最遲必須在提交申請後的30天內遞交。

在填妥表格後, 學校必須通過電子方式把表格傳給HHTOffice@mcpsmd.org。

HHT將以虛擬形式進行。個別的例外情況必須經過HHT主管的審查和批准。

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 _____

在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)

學生是否參加住院治療中心(RTC)、部分住院計畫(PHP)或重症門診計畫(IOP)?
❑ 是 ❑ 否?

如果回答是, 請提供計畫的名稱 _____

地址 _____

機構聯繫人: _____

聯繫人電子郵件 _____聯繫人電話 _____-_____-_____

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) _____

我授權蒙郡公立學校(MCPS)諮詢為我孩子治療的醫師/註冊護士, 確認診斷結果並/或說明醫學符號。我知道, MCPS在確認是否需要提供居家和醫院教學之前有權暫不提供服務。

家長/監護人簽名 _____ 日期 ____/____/_____

(見背面)

II. TO BE COMPLETED BY COUNSELOR/PRINCIPAL/DESIGNEE. PLEASE PRINT OR TYPE(由輔導員/校長/指定負責人填寫)

For students with an IEP or 504 Plans

❑ This student has an Individualized Education Program (IEP). IEP Case Manager: _____

❑ This student is in a discreet special education program: _____

❑ This student has a 504 plan.

❑ Most recent IEP or 504 plan attached to application (required for application approval). _____

School teams must conduct an IEP/504 review meeting within ten (10) days of the approval of the application.

For All Students

Accommodations attempted at the school to support student attendance (Please includes dates and results of any EMT meeting and/or parent conferences related to this application): _____

_____

_____

_____

_____ _____

Date application given to parent/guardian____/____/_____ Date application returned from parent/guardian ____/____/_____

By signing, the principal/principal designee understands that developing and submitting a return to school plan is required for every application. Approval of subsequent applications are partially contingent upon implementation of the aforementioned plan. If this is not the initial application for the student, please attach documentation of the results of the previous return to school plan with this application.

Date school submitted application to HHT Office ____/____/_____

Counselor/Principal/Designee Signature _____Date ____/____/_____

COUNSELOR/PRINCIPAL/DESIGNEE SHOULD SCAN AND EMAIL THE COMPLETED APPLICATION TO HHTOFFICE@MCPSMD.ORG

III. TO BE COMPLETED BY PHYSICIAN OR CERTIFIED NURSE PRACTITIONER ONLY. PLEASE PRINT OR TYPE.(僅供醫生或執業護士填寫)

PSYCHIATRIST/PSYCHOLOGIST/CERTIFIED MENTAL HEALTH NURSE PRACTITIONER VERIFICATION

For Mental Health Conditions Only

To be completed by a

licensed psychiatrist, licensed psychologist, certified mental health nurse practitioner, or certified school psychologist

Dear Mental Health Professional:

Before processing a request for Home and Hospital Teaching (HHT), a verification made within **30 days** of this application of the student's emotional condition from a licensed psychiatrist, psychologist, or certified mental health nurse practitioner is required. Student need for HHT must be reviewed every **60 calendar days** after the initial date of verification by the practitioner, or sooner at the request of the parent/guardian or MCPS.

Please provide the information requested below. You may attach this information to this signed document in lieu of responding on the form itself. Please note that missing information will result in a delay in processing the application.

1. Student Name _____
2. Have you completed an application for this student previously? ❑ Yes ❑ No
   If yes, how many applications have you completed this school year? ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6
3. Diagnosis of mental health conditions which prevent school attendance (Include DSM-V code):

   _____

   _____

   _____

   _____
4. Specify why the mental health condition prevents the student from attending their school of enrollment.

   _____

   _____

   _____

   _____
5. Date of most recent appointment ***(must be within 30 calendar days of the submission of this form to HHT Office)*** ____/____/_____
6. How often is the student seen in your office: _____
7. Is the student currently in therapy? ❑ Yes ❑ No

   Therapist's name _____

   Therapist's contact _____

   Frequency of visits _____
8. Is the student currently taking any medication? ❑ Yes ❑ No

   Medicine/Dosage _____

   _____
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 student's school of enrollment with modifications. Please list necessary modifications below.
    ❑ Student is able to attend school part-time ❑ Yes ❑ No

    _____

    _____

    _____

    _____

11. Regimen of Treatment to be Prescribed: (Indicate number of previous visits, general nature and duration of treatment, including referral to other provider of health services. Include a schedule of future visits or treatment since you are deeming it medically necessary for the student to be out of school for an extended period of time. You may attach documentation to this application:

_____

_____

_____

_____

12. Please list actionable steps the school can take, in your estimation, to support the student in returning to school by the end of the requested duration of services:

_____

_____

_____

_____

I certify that:

❑ I am a licensed psychiatrist, psychologist, or certified mental health nurse practitioner 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.

❑ I understand that I am part of the support team for this student and I will communicate with the school to assist in ensuring the student's return to school as quickly as is reasonably possible.

❑ I understand that by signing this application, the parent/guardian/caregiver of the named student has given authorization for me to discuss and clarify any of the information I have provided with Montgomery County Public Schools.

Signature of Certifying Professional_____Date ____/____/_____

Printed Psychiatrist, Psychologist/CMHNP Name_____

License Number _____

Address_____ Phone _____-_____-_____

Email address_____

IV. 返校計畫

應當通過以下人員之間的合作來制定返校計畫: 學校(建議學校團隊包括以下成員: 學校輔導員、學校心理學家、學生人事專員、領導、團隊帶頭人、學校其他工作人員(在適當時))、學生(如有可能)、家長和醫師, 從而概述各方將要採取的步驟, 以促進學生在規定的服務期結束前重返校園。學校應當記錄計畫每個部分取得的成功或面臨的挑戰。如果在本申請的服務期限結束時需要繼續提供服務, 學校將需要提交返校計畫的事實證據, 以及考慮到任何新信息的更新計畫。

請注意, 返校計畫可以在可行的情況下盡快實施, 而且不應推遲到所要求的服務期限完全結束時。

返校計畫應當考慮以下問題:

1.學校將安排哪些支持服務來幫助學生順利重返校園? 一些需要考慮的事項:

- 確定在學生返校時將與學生碰面的值得信任的成年人, 以及學校工作人員為支持學生返校而在第一天/週/月/等將要採取的措施。
- 為學生找一名午餐/報到夥伴。
- 安排學生在課外時間來學校適應校舍、查看課程表等。
- 安排與輔導員或其他值得信任的學校工作人員定期會面。

2.如果學生有504計畫或IEP, 團隊什麼時候會開會確定是否需要修訂或額外的適應性調整(續延申請應當包括這次會議的記錄)?

3.如果學生目前沒有504計畫或IEP, 是否需要召開一次EMT會議, 以便確定這名學生在返校時是否需要成文的適應性調整?

4.父母將採取哪些步驟確保學生在重返校園時能夠按時出勤?

5.醫師可以採取哪些具體步驟支持出勤? 學校將如何及在何時與醫師溝通並獲得這項資訊?

6.學校將如何支持學生重返校園?

這不是一份詳盡的清單, 學校、學生、家長和醫師應當納入一切必要的內容, 以確保為學生返校提供一個友善、安全的環境。下面是返校計畫的範例, 可以幫助您為這名學生制定一份成功的計畫:

小學

中學

高中