臨時教學服務申請(僅限符合條件的心理健康狀況)
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)辦公室使用这份表格獲取精神科醫師/心理醫生的建議和家長/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。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#__________

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/精神科醫師/心理醫生, 確診診斷結果並/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: 請學生的執業精神科醫師、執業心理學家或獲得認證的學校心理學家填妥這份表格的第2頁，然後把整份申請表交給學校。

(見背面)
PSYCHIATRIST/PSYCHOLOGIST VERIFICATION
For Mental Health Conditions Only
To be completed by a licensed psychiatrist, licensed psychologist, or certified school psychologist

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 _____-_____-______