임시 교습 서비스 지원서(승인된 정신 건강 상태인 학생용)
Application for Interim Instructional Services, with Qualified Mental Health Condition ONLY

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

메모: 이 양식은 임시 교습 서비스(Interim Instructional Services-IIS) 사무실이 정신과의/정신분석학의의 추천과 정신건강 관련 상태 학생의 교습을 시작하기 위해 학부모/후견인의 승인을 위한 양식입니다. 양식을 작성하여 학교 학교의 카운슬러 또는 학교장/대리인에게 제출합니다. 자체한 안내는 MCPS Regulation IOE-RB, Interim Instructional Services를 봅시다.

60일 이후의 경우, 완성한 새 지원서를 계속 제출해야 합니다.

1. 학부모/후견인이 작성해야 합니다. 정자로 쓰거나 타자로 기재합니다.

학생 이름 (성, 이름, 미들네임) ____________________________________________ MCPS 학생번호# ________
MCPS 학교 ___________________________________________ 학년 ______ 마지막 출석일 ______________
MCPS에서 보관하는 파일에 있는 학생의 집 주소가 정확합니다: ❑ 예 ❑ 아니오 (아니오의 경우, 학생 학교에 정확한 주소를 제공해야 합니다.)

학부모/후견인 성명 (프린트체로 기재) __________________________________________________________________________
학부모/후견인 전화 번호 집 직장  _______-_____-______  내선번호 _______-_____-______  휴대전화 _______-_____-______
부모/후견인 이메일 주소 ______________________________________________________________________________________

관계 ❑ 어머니 ❑ 아버지 ❑ 후견인 ❑ 기타(구체적으로 적을 것) ______________________________________________

학부모/후견인 성명 (프린트체로 기재) __________________________________________________________________________
학부모/후견인 전화 번호 집 직장 _______-_____-______  내선번호 _______-_____-______  휴대전화 _______-_____-______
부모/후견인 이메일 주소 ______________________________________________________________________________________

관계 ❑ 어머니 ❑ 아버지 ❑ 후견인 ❑ 기타(구체적으로 적을 것) ______________________________________________

교습을 받을 수 있는 시간을 표시합시다: ☑ 주중 ☑ 저녁 ☑ 주말

본인은 Montgomery County Public Schools(MCPS)가 우리 아이를 치료하고 있는 정신과의/정신분석의의 진단과 의학적 표기를 명확하게 하기 위해 정신과의/정신분석의의와의 상담을 승인합니다. 본인은 MCPS가 임시 교습 서비스를 위한 필요가 확인될 때까지 서비스를 보류할 권리가 있음을 약합니다.

서명, 부모/후견인 __________________________________________________________________________ 날짜 ______/____/_____ 

II. 카운슬러/학교장/대리인이 작성합니다. (TO BE COMPLETED BY COUNSELOR/PRINCIPAL/DESIGNEE.) 정자로 쓰거나 타자로 기재합니다. (PLEASE PRINT OR TYPE.)

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

학부모/후견인: 자격증을 갖춘 정신과 의사, 심리학자, 학교 심리학자가 이 양식의 2쪽을 작성해야 하며, 작성 후 모든 양식을 학교에 제출해야 합니다. (PLEASE HAVE STUDENT’S LICENSED PSYCHIATRIST, LICENSED PSYCHOLOGIST, OR CERTIFIED SCHOOL PSYCHOLOGIST COMPLETE PAGE 2 OF THIS FORM AND THEN SUBMIT THE ENTIRE APPLICATION TO THE SCHOOL.)

(뒤를 붙입니다)
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? Q Yes Q No Therapist’s name ____________________________
Phone _____-_____-______ Frequency of visits __________________________ Date of last visit ____/____/_____

6. Is the student currently taking any medication? Q Yes Q 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:
Q Student is unable to attend school
Q Student is able to attend regular day program and their school of enrollment with modifications
Q Student is able to attend school part-time Q a.m. or Q p.m.

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

Q I am a licensed psychiatrist or licensed psychologist and am currently treating this student; or
Q 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
Q 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 _____-_____-______