臨時教學服務申請(僅限於符合條件的身體健康狀況)

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*。

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, 但是必須在提交申請後的30天內遞交。

在填妥後, 學校必須通過電子方式提交給IISOffice@mcpsmd.org。

IIS將以虛擬形式進行。個別的例外情況必須經過臨時教學服務部主管的審查和批准。

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 _____

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) _____

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) *(please notify IIS office when IIS IEP is complete)* ❏ Section 504 Plan

❏ Student is enrolled in a discreet program (Name of Program)_____

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

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

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

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

III.僅供醫師/執業護士填寫。請用正楷填寫或打印。

MEDICAL VERIFICATION
For Physical Health Conditions Only

Dear Physician or Certified Nurse Practitioner (CNP):

Before processing a request for Interim Instructional Services (more commonly known throughout the state as "Home and Hospital Teaching"), a verification made within **30 days** of this application of the student's physical health condition from a physician or CNP is required. Student need for IIS 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.

1. Student Name _____

2. 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.

   _____

   _____

   _____

   _____

3. Reasons the condition prevents the student from attending school.

   _____

   _____

   _____

   _____

3. Date of most recent appointment *(must be within 30 calendar days of the submission of this form to IIS Office)*   ____/____/_____

4. Is this condition contagious?   ❏ Yes   ❏ No
   If yes, please explain _____

   _____

5. Is the student currently taking any medication?   ❏ Yes   ❏ No
   Medicine/Dosage _____

   _____

6. Requested duration of services *(no more than 60 days)*_____

7. 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

8. 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 physician or certified nurse practitioner and am currently treating this student.

❏ This student IS NOT able to attend the regular day program at their school of enrollment because of their physical 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 Physician/CNP _____ Date ____/____/_____

Printed Physician/CNP Name_____ License Number_____

Address _____ Phone _____-_____-_____

Email address _____

IV. 返校計畫

返校計畫應當通過學校、學生(可能時)、家長和醫師之間的合作來制定, 概述各方將要採取的步驟, 以便學生在要求的服務期結束前返回學校。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返校? 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返校的過渡期間會到校?

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業者溝通並獲得這項資訊?

6.學校將如何支持學生返回校舍?

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