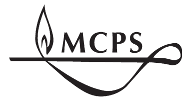
Application for Interim Instructional Services, with Qualified Physical Health Condition ONLY



Department of Career Readiness and Innovative Programs
Interim Instructional Services
MONTGOMERY COUNTY PUBLIC SCHOOLS (MCPS)
CESC, Room 251, Rockville, Maryland

MCPS Form 311-15B
October 2016

Note: This form is used by the Interim Instructional Services (IIS) Office to obtain physician's recommendation and parent's permission to initiate instruction for students with a medical health condition. Return completed application to student's school counselor or principal/designee.

A new completed application is required for continuation of service beyond 60 calendar days.

I. TO BE COMPLETED BY PARENT/GUARDIAN. PLEASE PRINT OR TYPE.

Student Name____MCPS ID#___________ DOB___/___/_____

MCPS School_______________________________________ Grade_____ Last day of school attendance __________

Home Address______________________________________ City _______________ State____ Zip Code_______

Edline User Name___________________________________ Edline Password ______________________________

Parent/Guardian Name *(please print)* ______________________________ E-mail ______________________________

Parent/Guardian Telephone Number Home ____-____-_____ Work____-____-_____ ext.____ Cell ____-____-_____

Relationship ☐ Mother ☐ Father ☐ Guardian ☐ Other (specify) ____

Parent/Guardian Name *(please print)* ______________________________ E-mail ______________________________

Parent/Guardian Telephone Number Home ____-____-_____ Work____-____-_____ ext.____ Cell ____-____-_____

Relationship ☐ Mother ☐ Father ☐ Guardian ☐ Other (specify) ____

Please check the times your child is available for instruction: ☐ Weekdays ☐ Evenings ☐ Weekends

I authorize Montgomery County Public Schools (MCPS) to consult with the physician/certified nurse practitioner treating my child to confirm the diagnosis and/or clarify the medical notations. I am aware MCPS has the right to withhold service until the need for Interim Instructional Services has been confirmed.

Signature of Parent/Guardian ____ Date ___/___/_____

II. TO BE COMPLETED BY COUNSELOR/PRINCIPAL/DESIGNEE. PLEASE PRINT OR TYPE.

Does this student have: ☐ IEP ☐ 504 (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 ___/___/_____

PLEASE HAVE STUDENT'S LICENSED PHYSICIAN OR CERTIFIED NURSE PRACTITIONER COMPLETE PAGE 2 OF THIS FORM.

(see back)

Student Name____

MEDICAL VERIFICATION

For Physical Health Conditions Only

To be completed by the **Physician/Certified Nurse Practitioner**

Dear Physician or Certified Nurse Practitioner (CNP):
Before processing a request for Interim Instructional Services (IIS), a verification of the student's physical health condition from a physician or CNP is required. Service needs must be reviewed every 60 calendar days after the initial determination of eligibility 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. 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.

   ____

   ____

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

   ____

   ____

3. Is this condition contagious? ☐ Yes ☐ No Describe____________________________
4. What, if any, medication is the student receiving? ____________________________
5. Describe the treatment that will be implemented to assist the student's return to school

   ____

   ____

6. Recommendations for school attendance
   ☐ Unable to attend school
   ☐ Able to attend school part-time ☐ a.m. or ☐ p.m.
7. Requested duration of services____________________________ **(no more than 60 days)**
8. Recommendation regarding school participation (i.e., activities to avoid, activities to encourage)

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I certify that:

- **I 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 condition.**
- **I understand that students approved for full time IIS typically receive 6 hours of instruction per week and that these services are the student's only source of instruction.**

Signature of Physician/CNP ____________________________________Date ____/____/_____

Printed Physician/CNP Name ______________________________ License Number____________________

Address____ Phone _____-_____-______