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 248, Rockville, Maryland

MCPS Form 311-15B
July 2018

CLEAR FORM

Note: This form is used by the Interim Instructional Services (IIS) Office to obtain a physician's recommendation and parent/guardian permission to initiate instruction for students with a medical health condition, other than a mental health condition. Return completed application to student's school counselor or principal/designee. For more information, see MCPS Regulation IOE-RB, *Interim Instructional Services*.

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 -- Choose One -- _____ Grade_____ Last day of school attendance _____

Home Address_____ City _____ State_____ Zip Code_____

MCPS Google E-Mail Address_____ MCPS Google Account 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: ☐ 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 ____/____/_____

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 made within 30 days of this application 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. Date of most recent appointment ____/____/_____

4. Is this condition contagious? ☐ Yes ☐ No Describe_____

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

6. Describe the specific strategies that you, as the referring professional, will implement to assist the student's return to school (transition plan).

   _____

   _____

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
☐ Student is able to attend school part-time ☐ AM ☐ PM

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

8. Anticipated date student will return to school ____/____/_____

9. Recommendation regarding school participation (i.e., activities to avoid, activities to encourage)

   _____

   _____

   _____

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.

Signature of Physician/CNP _____Date ____/____/_____

Printed Physician/CNP Name _____ License Number_____

Address_____Phone _____-_____-_____