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

CLEAR FORM

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

Note: This form is used by the Interim Instructional Services (IIS) Office to obtain a physician or certified nurse practitioner recommendation and parent/guardian permission to initiate instruction for students with a physical 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 (Last, First, MI) _____ MCPS ID#_____

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

The student's home address on file with MCPS is accurate: ☐ Yes ☐ No *(If no, you must update your address with the student's home school)*

Parent/Guardian Name (please print) _____

Parent/Guardian Telephone Number Home _____-_____-_____ Work_____-_____-_____ ext._____ Cell _____-_____-_____

Parent/Guardian E-mail Address_____

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

Parent/Guardian Name (please print) _____

Parent/Guardian Telephone Number Home _____-_____-_____ Work_____-_____-_____ ext._____ Cell _____-_____-_____

Parent/Guardian E-mail Address_____

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 ____/____/_____

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

PARENT/GUARDIAN: PLEASE HAVE STUDENT'S LICENSED PHYSICIAN OR CERTIFIED NURSE PRACTITIONER COMPLETE PAGE 2 OF THIS FORM AND THEN SUBMIT THE ENTIRE APPLICATION TO THE SCHOOL.

(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 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. 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).

   _____

   _____

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

8. 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

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 _____-_____-_____