

Application for Interim Instructional Services, with Qualified Mental 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 311-15C
July 2018
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Note: This form is used by the Interim Instructional Services (IIS) Office to obtain a psychiatrist's/psychologist's recommendation and parent/guardian permission to initiate instruction for students with 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 _____ 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/psychiatrist/psychologist 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 PSYCHIATRIST OR PSYCHOLOGIST
COMPLETE PAGE 2 OF THIS FORM.**

Student Name _____

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 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. 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? Yes No Therapist's name _____
Phone ____-____-____ Frequency of visits _____ Date of last visit ____/____/____
6. Is the student currently taking any medication? Yes 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. Anticipated date student will return to school ____/____/____
11. Recommendations for school attendance:
 Student is unable to attend school
 Student is able to attend regular day program and their school of enrollment with modifications
 Student is able to attend school part-time a.m. or p.m.

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

- 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 ____-____-____