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

MONTGOMERY COUNTY PUBLIC SCHOOLS Maryland

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 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 (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/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 ____/____/_____

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

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

(see back)

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 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. 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. 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.
11. ❑ If checked, this student cannot access instruction virtually. Please provide details explaining why.
    _____
    _____
    _____
    _____

❑ 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 _____-_____-_____