

**MONTGOMERY COUNTY PUBLIC SCHOOLS****臨時教學服務申請(僅限符合條件的心理健康狀況)**

Interim Instructional Services  
MONTGOMERY COUNTY PUBLIC SCHOOLS (MCPS)  
CESC, Room 248, Rockville, Maryland

**說明:** 臨時教學服務(IIS)辦公室使用這份表格徵得精神科醫生、心理醫生或心理保健執業護士的推薦和家長/監護人的同意,以便為有心理健康問題的學生開始提供教學。請把填妥的申請表交回給學生的輔導員或校長/指定負責人。欲知更多資訊,請參見MCPS《規章IOE-RB, 臨時教學服務》。

**如果要在60個日曆日以後繼續接受服務,則必須遞交一份新的申請,其中應包含執業醫師做出的最新診斷和治療信息。**

申請人必須填寫和提交這份申請表的所有部分,我們才會考慮這份申請:

- I. 家長應填寫的部分,包括簽名
- II. 學校應填寫的部分
- III. 執業醫師的證明,包括學校可以採取哪些具體步驟來支持學生重返教學
- IV. 返校計畫:應當在提交申請前與所有相關人士就返校計畫展開討論。計畫最好能與申請表一同遞交,但是必須在提交申請後的30天內遞交。

在填妥後,學校必須通過電子方式提交給 [IISOffice@mcpsmd.org](mailto:IISOffice@mcpsmd.org)。

IIS將以虛擬形式進行。個別的例外情況必須經過臨時教學服務部主管的審查和批准。

**I. 由家長/監護人填寫。請用正楷填寫或打印。**

學生姓名(姓、名、中間名) \_\_\_\_\_ MCPS ID號碼# \_\_\_\_\_

MCPS學校 \_\_\_\_\_ 年級 \_\_\_\_\_ 最後一個上學日 \_\_\_\_\_

MCPS檔案中保存的學生住址準確無誤:  是  否 (如果回答否,您必須向學生住家所屬學校提供您的最新住址)

學生是否參加住院治療中心(RTC)、部分住院計畫(PHP)或重症門診計畫(IOP)?  是  否?

如果回答是,請提供計畫的名稱 \_\_\_\_\_

地址 \_\_\_\_\_

機構聯繫人: \_\_\_\_\_

家長/監護人姓名(請用正楷書寫) \_\_\_\_\_

家長/監護人電話號碼 住家 \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ 工作 \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ 分機 \_\_\_\_\_ 手機 \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

家長/監護人的電子郵件 \_\_\_\_\_

關係  母親  父親  監護人  其他(請說明) \_\_\_\_\_

家長/監護人姓名(請用正楷書寫) \_\_\_\_\_

家長/監護人電話號碼 住家 \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ 工作 \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ 分機 \_\_\_\_\_ 手機 \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

家長/監護人的電子郵件 \_\_\_\_\_

關係  母親  父親  監護人  其他(請說明) \_\_\_\_\_

我授權蒙郡公立學校(MCPS)諮詢為我孩子治療的醫師/註冊護士,確認診斷結果並/或說明醫學符號。我知道,MCPS在確認是否有需要提供臨時教學服務之前有權暫不提供服務。

父母/監護人簽名 \_\_\_\_\_ 日期 \_\_\_\_/\_\_\_\_/\_\_\_\_

II. 由輔導員/校長/指定負責人填寫。請用正楷填寫或打印。

Does this student have?  Individualized Education Program (IEP) (*please notify IIS office when IIS IEP is complete*).  Section 504 Plan

Student is enrolled in a discreet program (Name of Program) \_\_\_\_\_

Date application given to parent/guardian \_\_\_\_/\_\_\_\_/\_\_\_\_ Date application returned from parent/guardian \_\_\_\_/\_\_\_\_/\_\_\_\_

Date school submitted application to IIS Office \_\_\_\_/\_\_\_\_/\_\_\_\_

Counselor/Principal/Designee Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**COUNSELOR/PRINCIPAL/DESIGNEE SHOULD SCAN AND EMAIL THE COMPLETED APPLICATION TO [IISOFFICE@MCPSMD.ORG](mailto:IISOFFICE@MCPSMD.ORG)**

III. 僅供醫師/註冊執業護士填寫。請用正楷填寫或打印。

## PSYCHIATRIST/PSYCHOLOGIST/CERTIFIED MENTAL HEALTH NURSE PRACTITIONER VERIFICATION

**For Mental Health Conditions Only**

*To be completed by a*

***licensed psychiatrist, licensed psychologist, certified mental health nurse practitioner, or certified school psychologist***

Dear Mental Health Professional:

Before processing a request for Interim Instructional Services (more commonly known throughout the state as “Home and Hospital Teaching”), a verification made within **30 days** of this application of the student’s emotional condition from a licensed psychiatrist, psychologist, or certified mental health nurse practitioner is required. Student need for IIS must be reviewed every **60 calendar days** after the initial date of verification by the practitioner, or sooner at the request of the parent/guardian or MCPS.

Please provide the information requested below. You may attach this information to this signed document in lieu of responding on the form itself. Please note that missing information will result in a delay in processing the application.

1. Student Name \_\_\_\_\_
  2. Diagnosis (Include DSM-V code):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  3. Specify why the mental health condition prevents the student from attending their school of enrollment.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  4. Date of most recent appointment (**must be within 30 calendar days of the submission of this form to IIS Office**) \_\_\_\_/\_\_\_\_/\_\_\_\_  
How often is the student seen in your office: \_\_\_\_\_
  5. Is the student currently in therapy?  Yes  No  
Therapist’s name \_\_\_\_\_
  6. Is the student currently taking any medication?  Yes  No  
Medicine/Dosage \_\_\_\_\_  
\_\_\_\_\_  
How does medication impact school performance? \_\_\_\_\_  
\_\_\_\_\_
  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. Please list necessary modifications below.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- Student is able to attend school part-time  Yes  No

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

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10. Please list actionable steps the school can take, in your estimation, to support the student in returning to school by the end of the requested duration of services:

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**I certify that:**

- I am a licensed psychiatrist, psychologist, or certified mental health nurse practitioner 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.
- I understand that I am part of the support team for this student and I will communicate with the school to assist in ensuring the student's return to school as quickly as is reasonably possible.
- I understand that by signing this application, the parent/guardian/caregiver of the named student has given authorization for me to discuss and clarify any of the information I have provided with Montgomery County Public Schools.

Signature of Certifying Professional \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Printed Psychiatrist, Psychologist/CMHNP Name \_\_\_\_\_

License Number \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Email address \_\_\_\_\_

#### IV. 返校計畫

應當通過以下人員之間的合作來制定返校計畫: 學校(建議學校團隊包括以下成員: 學校輔導員、學校心理學家、學生人事專員、領導、團隊帶頭人、學校其他工作人員(在適當時))、學生(如有可能)、家長和醫師, 從而概述各方將要採取的步驟, 以推動學生在要求的服務期結束前返回學校。學校應當記錄計畫每個部分取得的成功或面臨的挑戰。如果在本申請的服務期限結束時需要繼續提供服務, 學校將需要提交返校計畫的事實證據, 以及考慮到任何新信息的更新計畫。

請注意, 返校計畫可以在可行的情況下盡快實施, 而且不應推遲到所要求的服務期限完全結束時。

返校計畫應當考慮以下問題:

1. 學校將安排哪些支持服務來幫助學生返校? 需要考慮的事項:

- 確定在學生返校時將與學生碰面的值得信任的成年人, 以及學校工作人員為支持學生返校而在第一天/週/月/等將要採取的措施。
- 為學生找一名午餐/報到夥伴。
- 安排學生在課外時間來學校適應校舍、查看課程表等。
- 安排與輔導員或其他值得信任的學校工作人員定期會面。

2. 如果學生有504計畫或IEP, 團隊什麼時候會開會確定是否需要修訂或額外的適應性調整(續延申請應當包括這次會議的記錄)?

3. 如果學生目前沒有504計畫或IEP, 是否需要召開一次EMT會議, 以便確定這名學生在返校時是否需要成文的適應性調整?

4. 父母將採取哪些步驟確保學生在返校的過渡期間會到校?

5. 醫師可以採取哪些具體步驟支持出勤? 學校將如何及在何時與醫師溝通並獲得這項資訊?

6. 學校將如何支持學生返回校舍?

這不是一份詳盡的清單, 學校、學生、家長和醫師應當納入一切必要的內容, 以確保為學生返校提供一個友善、安全的環境。下面是返校計畫的範例, 可以幫助您為這名學生制定一份成功的計畫:

[小學](#)

[中學](#)

[高中](#)