Woodstock Community Unit School District #200
Other health impairment Eligibility Criteria

State Definition:

Other Health Impairment means having limited strength, vitality or alertness, including a heightened sensitivity to environmental stimuli, that results in limited alertness with respect to the educational environment that

- Is due to chronic or acute health problems such as asthma, attention deficit disorder or attention deficit hyperactivity disorder, diabetes, epilepsy, a heart condition, hemophilia, lead poisoning, leukemia, nephritis, rheumatic fever, or sickle cell anemia; and
- Adversely affects a child's educational performance.

The Illinois definition is synonymous with the federal definition.

Section I: Eligibility Criteria

OHI is not a default category and must be addressed like the other impairment categories.

What OHI is	What OHI is not
An impairment requiring a complete evaluation by an IEP team, just like other impairment categories	A default or back-up category if the child does not meet eligibility criteria for another impairment (for example, behavior is severe, chronic, and frequent but not across settings does not mean the student is OHI. It only means he/she is not EBD)
A wide range of health conditions with symptoms ranging from mild to severe	Generally the impairment category for students with mental health diagnoses
A wide range of service needs ranging from constant to intermittent	If the adverse effect on education is primarily due to active substance abuse (alcohol or other drugs)
A continuum of options and services	A disability more accurately described by another impairment
A focus on presenting problems or issues (not automatic entitlements)	An automatic entitlement for students with any diagnosed medical condition including ADD/ADHD (must meet criteria and "need" for special education)

OHI is not a way to avoid difficult discussions about labels.

The student must have a health condition, but **a medical diagnosis** is not required.

Criteria: There are three sections in the Illinois criteria as follows:

1. **Limited strength, vitality or alertness**: only one of the three must apply in any individual case. There is no official definition of these terms, either at the federal or state level. However, by looking online, in the dictionary, and in a thesaurus, the following definitions may be helpful. Keep in mind there may be too much vitality or alertness, especially when the student has ADD/ADHD.

    - **Strength**: bodily or muscular power; vigor, durability related to decreased capacity to perform school activities; tires easily, chronic absenteeism related to the health problem. For instance, can the student sit or stand as required by school activities? Is the student able to hold a pencil or use other classroom tools? Does the student fall asleep or require frequent rest breaks due to the health problem?
    - **Vitality**: physical and mental strength; capacity for endurance; energy; animation; activity. There is certainly overlap in the meanings of these three terms. A student might have the strength to sit up or hold a pen, for example, but might not have the energy to complete the task at hand.
    - **Alertness**: attentiveness; awareness; keen; observant; watchful; on guard; ready. Is the student aware of his/her surroundings and the activities going on? Does he/she have the mental acuity to participate in the lesson or activity?
2. **Chronic or acute health problem**: note there is no specified length of time for the health problem to be present or to continue. Students with chronic health problems may need intermittent services, especially if their illness is cyclical or may recur necessitating additional treatment. It is not important to determine whether the health problem is chronic or acute. These terms are included to indicate the problem may be either, and it is not a distinction on which to spend discussion time in terms of eligibility. If it can be determined whether the problem is chronic or acute, it may be helpful in programming decisions.
    - **Chronic**: long term and either not curable **or** there are residual features resulting in limitations of daily living functions requiring special assistance or adaptations **or** the disease or disorder that develops slowly and persists for a long period of time, often the remainder of the life span; may include degenerative or deteriorating conditions.
    - **Acute**: begins abruptly and with marked intensity, then subsides **or** has a rapid onset, severe symptoms, and a short course; sequelae may be short term or persistent.

3. **Adversely affecting a child's educational performance**: it is important to structure the IEP team discussion and discuss how the child's education is affected. This information will be critical if the student is found to be a child with a disability, and an IEP is going to be developed.

Describe how the health problem is manifested at school, including implications for programming. Following are some issues to consider, and not all will apply to every student. There is overlap between these areas and it is more important to identify the issues and needs for an individual student than to try to categorize. Please note this is the third part of the eligibility criteria and each of these areas should be considered as they relate to the student's health condition, rather than as they may apply to another disability. For example, behavior and social skill functioning

- **Pre-academic, academic, and classroom performance**
  - Is the student making appropriate progress from year to year?
  - How does the student function in the classroom? In large groups? Small groups? In unstructured time? Independently? One on one?
  - What about the traditional measures of academic achievement: grades, tests, daily work, etc.?
  - Is the student functioning significantly below grade level and/or ability?
  - Is the student able to successfully complete academic or developmental tasks?
  - Is there a significant effect on the student's attendance?
  - Does the student require medication that can impact strength, vitality, and/or alertness?
  - Do health care procedures take time away from instruction?
  - Are there some issues with scheduling – revising the schedule to allow for rest breaks, scheduling classes so as not to conflict with health care procedures?
  - Is the student in chronic pain, reducing endurance or stamina? Are there better or worse times of the day, and can we accommodate through re-arranging the child's schedule?
  - Does the student have heightened or diminished alertness (e.g., the student is overactive or underactive)?
  - Does the student have difficulty with time management and organizational skills?
  - What about following directions and task completion? Is there a decrease or change in work output?
  - Does the student have memory problems (such as short-term memory or difficulty recalling information?
  - Is the student easily distracted, requiring frequent redirection or supports to remain on task or complete a task?

- **Attendance and loss of instructional time**
    - Does the student have excessive absences due to the medical condition? There are no specific numbers of minimum attendance, or maximum absences. Do the health-related absences create gaps in the student's education? If the absences are related to the health condition, are services provided while the student is unable to attend school?
    - If absences are primarily due to school phobia, truancy, excessive anxiety, or lack of motivation unrelated to the health problem, an evaluation for EBD might be more appropriate.
    - Does the student miss instructional time due to health care procedures necessary at school? Does medication cause memory, attention, or fatigue issues?
    - Does the student have difficulty breathing? Does the student expend a great deal of effort in breathing, necessitating frequent rest breaks?

- **Behavior and social skill functioning related to the health condition**
    - Is the student's behavior interfering with his or her learning or that of others? Keep in mind that "behavior" includes not only acting out or disruptive behavior but also passive resistance or withdrawal.
    - Does the student have prolonged periods of absence from school so is isolated from his/her peers? Do the prolonged absences contribute to the student knowing and understanding school rules and expectations? Does the health condition interfere with a student developing relationships with peers and/or with adults in the school setting?
    - What about non-academic activities (e.g., recess, lunch, physical education, study hall, field trips), unstructured times, transitions from activity-to-activity or location-to-location? Are there accommodations or modifications the student may need in order to participate?
    - Is the student reluctant to attempt new tasks because they may be painful or difficult?
    - Is the student self-conscious and perhaps overly defensive about his/her health condition?

- **Communication and breathing**
    - Is the student's communication impacted by the health condition? Consider both written and verbal communication.
    - Is the impact the result of an illness or trauma, rather than a developmental issue?
    - Does the student have breath support problems or weak neck and head muscles such as might occur with cerebral palsy?
    - Has the student had a stroke? Does the student have a degenerative disease?

  - Has the student had surgery? Throat cancer? Use an augmentative device to communicate?
  - Has a limb been amputated or severely injured, making writing or keyboarding difficult?

- **Motor skills**
  - Does the student have gross and/or fine motor skill deficits related to the health problem? Are there strength or balance issues? Is the student's posture affected by the health condition?
  - Can the student move within typical timelines? Does the student have difficulty moving around the classroom, from classroom to classroom, and to other areas within the school building and property? Is the student able to move up and down stairs? Can he/she keep pace with peers?
  - Can the student manage toileting and other personal care skills?
  - Does the student have muscle weaknesses? Does the student have swelling or pain in the joints or muscles? Can the student grasp needed equipment such as pencils or eating utensils?

- **Adaptive skills, vocational skills, and transition planning**
  - What about adaptive skills (skills needed to be a part of the community, self-care, social skills, health and safety, etc.)?
  - Does the student need instruction in self-care skills? Note: this does not include simple medication administration or blood sugar monitoring.
  - Does the student need instruction in self-monitoring, self-management, self-advocacy?
  - Is there equipment the student must obtain and care for? This could include eyeglasses, a walker or wheel chair, cleaning supplies such as alcohol wipes or sterile gauze, etc.
  - What about organizational skills? Consider record keeping, organization medications so they are taken correctly, keeping a calendar of appointments, making a list of health care providers, keeping a list of prescription and over the counter medications and supplies.
  - Does the student understand his/her dietary and nutrition needs, and can the student follow those?
  - Can the student read, understand and implement directions and labels?
  - What about vocational/transition issues (e.g., community use, work, health care, self-direction, housing etc.)? What careers might be appropriate for the student? What additional education or training might be needed and how would the student access those programs?

What accommodations and modifications might the student need in a job or post secondary education setting?
- What financial resources might the student need to access for housing, health care, post-secondary education, etc.?
- Upon reaching the age of majority (18) will the student need to document disability again and apply/re-apply for Medicaid or other health coverage?

Does the adverse affect of the health condition on education require special education?

The three questions to be addressed in documenting need for special education are:

1. ***Does the student have needs that cannot be met in regular education as structured?***
   If the answer is "yes", the needs are to be listed, and the discussion continues with question 2. If the answer is "no", there is no need for special education and the discussion ends at that point.
2. ***Are there modifications that can be made in the regular education program to allow the student access to general education curriculum and to meet the educational standards that apply to all students?***
   (Consider adaptation of content, methodology and/or delivery of instruction.) if the answer is "yes", then list (a) modifications that do not require special education, and (b) those modifications that require special education, and go to question 3. If the answer is "no", then proceed to question 3.
3. ***Are there additions or modifications the child needs, which are not provided through the general education curriculum?***
   (Consider replacement content, expanded core curriculum, and/or other supports.) If yes, then the additions or modifications are to be listed.

Eligibility requires the IEP team to have answered "yes" to questions 1, 2b and and/or 3.

Students who are not found eligible for special education under IDEA may be eligible for accommodations and modifications under section 504 of the rehabilitation act of 1973.

Some students may be exceptions to the general practices, such as high-functioning student with Down syndrome who has heart problems but no cognitive disabilities. Another example may be a student suffering from Post-Traumatic Stress Disorder (PTSD), and the PTSD diagnosed within a short time of the trauma. Thus the behavior does not meet the "chronicity" for EBD.

Section II: Evaluation/Re-evaluation for OHI

One of the most common complaints about application of the OHI criteria is the interpretation of OHI as a "default" category. In other words, if the student does not meet the eligibility criteria for another area of disability, the decision is made to call the student OHI. An IEP team should not be identifying a student as OHI without having conducted an appropriate evaluation or re-evaluation.

Review existing data to determine what additional information is needed? Existing data may include review of records, including health records (if any), information provided by the parents, attendance records, classroom observations, grades and report cards, work products, and standardized testing, including statewide and district wide assessments and previous evaluations. If additional evaluations are needed, it might include additional testing such as intelligence or achievement tests, rating scales, interviews, and observations. It might be appropriate to collect a health and social history. The IEP team should focus on the educational issues or problems a student presents and evaluate accordingly. For example, if the student struggles with organization, additional evaluation might include classroom observations, interviews with parents, the student and teachers, and review of work products such as an assignment notebook (if any) and how the student organizes his/her locker or backpack. If the student exhibits behavior problems, classroom observations behavior rating scales, and interviews might be appropriate measures.

If considering OHI, it is important to review medical and health records. A medical diagnosis is not required, but may certainly be helpful in determining not only eligibility, but also educational needs. If medical records are not available, the IEP team will have to rely on the information at hand, including the credibility of that information. If medical records exist, but the parents are not willing to release the information, perhaps school staff can prepare a list of questions and issues specific to the child's educational performance, and parents may reconsider.

When conducting a re-evaluation, either for a student already identified as OHI or if the addition of OHI is being considered, the IEP team should review the eligibility criteria, addressing:

- Does the health condition still exist?
- Does the health condition continue to have adverse effects on the child's educational performance?
- If the child is showing improvement in school performance, is it due to the interventions, modifications, and supports in place? What would happen if those services were withdrawn? Would the child regress and be unable to function independently without the supports, or has

the child developed the compensatory skills necessary to progress with the supports in place?
  - Are there changes in the child's health, such as new symptoms or treatments?
  - Does the child still need special education?

The Role of the School Nurse:

- Interpret medical records, help clarify how a diagnosis might impact a child's school performance, and discuss implications for programming;
- Serve as a liaison with parents, physicians, community health, and other health care providers;
- Promote good health practices and provide health education;
- Provide health care in a school setting;
- Collect and interpret medical information, such as efficacy of treatment and the implications for learning;
- Classroom observations of students with health-related concerns;
- Identify health barriers to learning;
- Provide training documented in program modifications (e.g., seizure management), chronic disease management, medications and possible side effects;
- Collect prenatal, early childhood, and health history from students and parents;
- Complete physical assessment and health screen (e.g., growth, hearing and vision screen, weight, etc.)'
- Provide medical case management;
- Make recommendations for the student's programming and school –based health services

Only medical personnel are authorized to conduct medical review; this excludes other support personnel, parents, administrators, and teachers

Only a person holding a School Service Personnel Certificate endorsed for school nursing shall make recommendations regarding educational interventions, accommodations or modifications based on the findings.

School health care and school nursing services do not require special education; an IHP is not a special education service.

Attaching an IHP to an IEP is generally not recommended because IHPs may have to change frequently. An IHP could reference an IEP, but the intent of an IHP is as a nursing care plan (what is the care needed and who will provide it), rather than addressing an education program or barriers to learning.

Medical records and medical diagnoses:

It may be helpful to have medical information, but a medical diagnosis is not legally required in order for a child to be evaluated for or identified as OHI. This includes students with ADD/ADHD. OHI is an educational disability and the determination is done by an IEP team. A physician may not prescribe special education. Medical records, including a physician's opinion and recommendations, are excellent sources of information, but it is the IEP team who determines eligibility for special education. A medical diagnosis is not an automatic qualification for OHI.

If the IEP team feels it must have medical information, and such information is not available, the IEP team must proceed using the information they have. IF parents are reluctant to release medical information to the school, perhaps school staff can draft some specific questions or issues they would like the physician or other medical personnel to address. The parent might be willing to allow limited information to be released in that way.

Attention deficit disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD) may require psychoeductional, cognitive, behavioral and/or psychological, or other evaluation procedures to determine eligibility under the disability category of "other health impairment". Because ADD or ADHD may coexist with other disabilities or conditions, the evaluation procedures must be sufficiently comprehensive to determine: whether the child may be primarily identified under "other health impairment" or another disability category; whether the child requires special education and related services; and to identify the child's other educational needs. A Medical diagnosis of ADD or ADHD is not necessarily required to determine whether a child is eligible for purposes of special education and related services under the IDEA. Licensed psychologists and certified school psychologist are qualified to conduct evaluations for the purpose of establishing the condition of ADD or ADHD. The multidisciplinary evaluation and eligibility group must determine whether the condition results in a disability, as defined under the IDEA, and whether the child requires special education and related services as a result of the disability.

Tourette Syndrome is a neurological disorder, not an emotional disorder. Tourette Syndrome is commonly misunderstood to be a behavioral or emotional condition, rather than a neurological condition.

Depending on the individual needs of the child, consideration of other special factors may be needed (e.g., Assistive Technology (AT), behavior, communication).

Content is modified from:

Wisconsin Department of Public Instruction, Special Education Eligibility Criteria and Evaluation for Other Health Impairment (OHI), August 2009
Other Health Impairment, A Guide for Supporting Children and Youth Served in Public Schools, Feb. 2010, Oklahoma State Department of Education

Other Health Impairment

Section III: Diagnoses and Conditions

The following list of conditions may be those that are most often seen in the classroom. The information about each condition is intended to be basic awareness material. As with all children in special education, children with special health care needs will be unique even within the same diagnoses. It is likely that the special educator will encounter conditions not listed here that might qualify a child for services within the other health impairment category.

Seizures

A seizure disorder consists of recurrent, unprovoked seizures caused by an abnormal cerebral electrical activity. Seizure activity, either a single occurrence or multiple occurrences that are caused by an acute incident are not considered epilepsy. The difference is if something unusual has caused the seizure or if seizures appear to happen without cause. Seizures can look very different based on the region of the brain that is involved. Onset of a seizure is sudden and involuntary. They can be precipitated by stressors such as fevers, illness or sleep deprivation. An episode can include loss or alteration of consciousness, involuntary movements or unusual sensations. Partial or focal seizures involve a specific area of the cortex. Generalized seizures are spread throughout both hemispheres of the brain. Typically a subdued, drowsy state with limited ability to focus and function (postictal state) follows a seizure where lethargy and sometimes observable neurological deficits, like pupil dilation, are present. Seizures can be classified into two broad categories, partial or generalized:

Partial Seizures (focal, local)

1. Simple Partial Seizures (consciousness not impaired)
    - With motor signs
    - With special sensory symptoms (visual; auditory; olfactory; gustatory; vertiginous)

    - With autonomic symptoms
    - With psychic symptoms (speech, memory, cognitive, and/or affective disturbance; illusions; structured hallucinations)
2. Complex Partial Seizures (consciousness impaired)
    - Simple partial onset followed by impairment of consciousness
    - Impairment of consciousness at onset

Generalized Seizures (bilateral, symmetrical)

1. Absence
    - With impairment of consciousness only
    - With clonic components
    - With tonic components
    - With automatisms
    - With autonomic components
2. Atypical absence seizures (more dramatic tone changes, less abrupt onset/end)
3. Myoclonic seizures

Clonic Seizures

1. Tonic seizures
2. Tonic-clonic seizure ("grand-mal")
3. Atonic

<u>Simple partial seizures</u> do not interfere with cognitive abilities. Students can respond while the seizure is occurring and can remember it afterwards. Jerking, stiffening, tingling in extremities, unusual smells, tastes or other sensations may be reported. With some seizures autonomic changes like changes in the heart rate and respiration may occur. Other symptoms may include "out-of-body" sensations, depersonalization, fear, anger and déjà vu perceptions.

<u>Complex partial seizures</u> result in consciousness being affected but not totally lost. Sometimes memory of the event may not occur. Often staring and unresponsiveness is observed. Automatisms like lip-smacking, grunting or chewing may also be present. Complex partial seizures sometimes become generalized after initial onset. If this occurs the student may recall the onset of the seizure but not recall events when it becomes generalized.

<u>Generalized seizures</u> take place over the entire cortex of the brain at the beginning of the event. They may include convulsive activity, tonic-clonic ("grand mal") or nonconvulsive ("petit-mal"). Usually an electroencephalogram (EEG) is required to

differentiate between a complex partial seizure and generalized nonconvulsive seizure.

Myoclonic seizures have rapid, involuntary jerks. Clonic seizures have repetitive and rhythmic muscle contractions. Tonic seizures involve muscle contractions and stiffening that lasts longer than a few seconds. Atonic seizures are those with loss of muscle tone.

Treatment of seizures includes anticonvulsant medications. These are usually prescribed after the first seizure. Some medications can, but not always, influence cognitive abilities including but not limited to word-finding limitations and appearing dull.

What You Can Do

During a seizure, do not attempt to restrict the student or their movement. Help the student to the floor and provide a pillow or something soft to prevent head injury. Move any furniture or objects that may cause injury. Do not put anything in the student's mouth. A seizing student cannot swallow his or her tongue, and you are more likely to injure the student or yourself by placing something in the mouth. Lay the student on his or her side. It is not uncommon for someone who has had a seizure to vomit, and this will help prevent the student from choking. Loss of bowel or bladder control may also occur. Develop a plan to provide the student with privacy. Often this may be as simple as providing a light blanket to cover any soiling that may occur.

Try to time the duration of the seizure. After a seizure confusion and disorientation may be observed. Reassure the student that he or she is safe. Someone should stay with the student and not allow them to eat or drink until fully recovered.

Coordinate with the child's parents and health care provider about what constitutes an emergency situation and what should be done should one arise. Typically, a seizure lasting more than five minutes or the student is having multiple seizures without regaining consciousness constitutes a medical emergency that requires advanced care. Always confirm these criteria with the family and the student's health care provider.

Organize how you and the family will communicate the occurrence of seizure activity. Collaborate with the parents to monitor the effectiveness of medications as well as any side effects. Typically you should plan to observe and report:

- Length of seizure;
- Symptoms or behaviors;
- Involuntary movement;
- Vomiting;
- Loss of bladder control;
- Loss of bowel control;
- Time of day;
- Preceding activities; and
- Frequency.

Children and youth with a seizure disorder must also deal with the psychological and social aspects of the condition. Public perceptions and fear of seizures, uncertain occurrence, loss of self control during the seizure episode, and compliance with medications contribute to misunderstanding. To help children feel more confident about themselves and accept their condition, the school can assist by providing epilepsy education programs for staff and students, including information on seizure recognition and first aid.

Sarco, D., Vanderbilt, D., Riveillo Jr., J., 2008. Central nervous system disorders, In Wolraich, M., Drotar, D., Dworkin, P., Perrin, E. Developmental-behavioral pediatrics: Evidence and practice, Mosby Elsevier, Philadelphia, PA.
Mauro, T., 2008. Preparing the school for your child with a seizure disorder.
http://specialchildren.about.com

Juvenile Arthritis

The Arthritis Foundation defines juvenile arthritis as a "general term for all types of arthritis and related conditions" occurring in approximately "300,000 children under the age of 17" <http://www.arthritis.org/diseasecenter.php # J>. Juvenile arthritis is an autoimmune disease. This means that the body attacks its own healthy cells and tissues.

There are three types of juvenile arthritis:

Pauciarticular juvenile arthritis involves fewer joints. About half of children with juvenile arthritis have the pauciarticular type. Sometimes only one joint will be involved, usually a knee or ankle, for about half the children and youth with this type of juvenile arthritis.

Polyarticular juvenile arthritis affects five or more smaller joints (such as the hands and feet). Usually, the joints are all on the same side of the body. However, this type of juvenile arthritis can also affect large joints.

Systemic juvenile arthritis causes swelling, pain, and limited motion in at least one joint, rash, and inflammation of internal organs such as the heart, liver, spleen, and lymph nodes.

Juvenile arthritis can look quite different in every child. Remissions (symptoms improve or disappear) may occur. There are other times when symptoms worsen (flare-ups). Sometimes, a child may have one or two flare-ups and never have symptoms again. Other children may have frequent flare-ups and symptoms that never go away. Children and youth with juvenile arthritis often see a pediatric rheumatologist.

Treatment options include:

Medications: Nonsteroidal anti-inflammatory drugs lessen the inflammation and help with pain management. These drugs include ibuprofen or naproxen. Another category of drugs are disease-modifying anti-rheumatic drugs used when anti-inflammatory drugs do not help. These categories of drugs are used to slow or stop progression of juvenile arthritis. Treatment with anti-rheumatic drugs is a long term approach and may take extended periods of time to be effective.

Therapy: It is important to maintain muscle tone to help with strength and range of motion. However, exercise must be balanced with rest. A physical therapist may be necessary to design an individualized program. Although pain sometimes limits sports and physical activity, children with juvenile arthritis can often fully participate when symptoms are under control. Swimming is a particularly good exercise, because it uses many joints and muscles, without putting weight on the joints.

Surgical Treatment: While most juvenile arthritis is treated with medications, in very severe forms or with complex problems, joint replacement surgery may be necessary.

A student's abilities to manage academics can be affected by juvenile arthritis. It is very important to identify the individual modifications needed by each child to assure that the school setting is accessible and that success with school work is attainable. A student's stamina and strength can be affected by juvenile arthritis. Some may come to school with pain and stiffness. The student may have intermittent absences due to flair-ups and go from a flair-up of symptoms to being nearly symptom-free.

What You Can Do

Always work closely with the family and their healthcare providers to understand how juvenile arthritis is manifested with each individual child. Modifications may be necessary when the child is experiencing a flair-up but at other times the child may be capable of managing his/her own limitations.

Ongoing communication between the student, family, teacher, and health care providers to maintain joint function, manage pain and use the student's coping strategies to the fullest extent is important. Very young children may have difficulty communicating how they are feeling, so learning to recognize nonverbal indicators is important.

A medication administration plan will need to be established. Depending on school policy, older students may manage their own medications while younger students will need supervision. Medication plans should include a mechanism to report to parents.

Stiffness and pain may result in slower dressing times, so accommodations after physical education classes may be needed. Also, transition between classes may need to be extended to accommodate a slower pace for students with juvenile arthritis. Allowing students opportunities to stretch to alleviate stiffness may be important. Two sets of books in different backpacks or book bags (one for the morning classes and one for the afternoon classes) may provide relief from heavy loads.

Writing and other fine motor skills may be compromised. Adaptive equipment like soft, foam tubes around pencils and pens, computers for all writing assignments, recording devices instead of handwritten lecture notes, a more comfortable desk, chair, and additional time to take tests are some of the adaptations to be considered. Some students may need assistance carrying heavy books and supplies and opening containers. The student's ability to effectively participate in emergency drills should be problem solved.

American Academy of Orthopedic Surgeons <http://orthoinfo.aaos.org>, 2009
Arthritis Foundation <www.arthritis.org 2008>

Asthma

Asthma, also referred to as Reactive Airway Disease (RAD), is a chronic condition of the lungs in which the airway is super sensitive and hyper-reactive. Although there is no cure for asthma, the symptoms can be controlled. Signs and symptoms range from mild wheezing to life-threatening asthma attacks.

Asthma attacks usually manifest in three ways:

- Inflammation of the airway and increased mucus, making the movement of air difficult;
- Spasms of the airway; and
- Bronchoconstriction, or tightening of the bronchial walls, making breathing difficult.

Asthma attacks may be triggered by a "cold" or upper respiratory infection. However, in some individuals, asthma attacks may be triggered by physical exertion or excitement. Environmental factors, such as mold, pollen, mildew, smoke (cigarette smoke as well as smoke from fireplaces or BBQs) are common triggers. Strongly scented cleaning solutions, chlorine bleach, ammonia and other chemicals such as paint, paint thinner, or insecticides may also trigger asthma attacks. Perfume may also trigger attacks. This may present difficulty in school when both staff and peers are asked to restrict their use of scented grooming lotions.

Early recognition of an asthma attack is important because treatment can be initiated before the situation becomes severe. Common symptoms include:

- Wheezing, coughing, or difficulty breathing;
- Tightness or pain in the chest;
- Rapid respirations;
- Shortness of breath; and
- Difficulty speaking.

Children with asthma should be observed more closely if they begin to have fever, sneezing, coughing, or signs of a cold or flu. Dark circles under the eyes and poor appetite may precede an asthma attack.

What You Can Do

Consult with the child's family and health care provider about what triggers an asthma attack. If you are aware of the trigger, whether it is physical exertion, illness, excitement, or environmental factors, you may be able to diminish the child's exposure to these stimuli. If cleaning products or art supplies (paints or paint thinners) trigger attacks, avoid using them in your classroom. If physical exertion or excitement are triggers, monitor the child closely during activities which produce these or substitute a nontrigger activity.

Having a plan of action developed prior to the occurrence of an asthma attack can prevent a medical emergency. Coordinate with the child's family about how an asthma attack is handled at home. If the child has medication or a rescue inhaler for use in an asthma attack, assure that it is available and that you are familiar with its use. Immediately after administering the medication or inhaler, notify the child's family. Have the child sit quietly and breathe deeply in through the nose and out the mouth. Never leave a child who is having an asthma attack unattended. If the symptoms do not improve or if they worsen, or if there are signs of cyanosis (blueness of the lips, tongue, or nail beds) call Emergency Medical Services 911. Consult with the student's family and health care provider about what constitutes an emergency and develop a plan to manage the situation if it occurs.

Asthma – Mayo Clinic,< www.mayoclinic.com/health/asthma> 2009.
American Lung Association,< http://www.lungusa.org/site/pp.asp?c=dvLUK9o0E&b=22582>, 2009
Hawaii Special Education Handbook,
<http://doe.k12.hi.us/specialeducation/SpEdHandbook2006/06appendix_a.htm#Asthma>, 2006

Gastrostomies, Tracheostomies and Ventilators

Surgically created openings in the body are called "ostomies." The actual end of the opening is referred to as the "stoma." Ostomies may be created to provide a way to remove substances from the body, as in a colostomy (to remove fecal matter from the colon) or urostomies (to remove urine from the bladder). Ostomies are also created to allow for food and liquid to be put into the body as in a gastrostomy (an opening into the stomach). Tracheostomies are openings in the throat into the trachea (windpipe) to allow or facilitate breathing, either naturally or with ventilator assistance.

Gastrostomy:

A child who cannot be fed by mouth or who cannot swallow can be fed through a tube inserted into the stomach through a gastrostomy. Liquids and blended foods are measured into a large container which is attached to the gastrostomy tube. The container is held higher than the child's stomach and the liquid/food flows by gravity or, in some cases, the tubing is attached to a special pump device. The child's health care provider will determine the amount and type of food that is appropriate for the individual child.

What You Can Do

Meal time should be a pleasant, social event for all children, including those being fed via a gastrostomy. Children with gastrostomies should be included with other children during regular meals. Consult with the child's family to learn which techniques work best. The child should be in a sitting or semi-sitting position during and following the feeding to help prevent vomiting. Very small children can be cradled in the arms of the caregiver during the feeding, making sure the head and upper body are elevated at least 45 degrees. Liquid food should be allowed to flow by gravity, or with a special mechanical pump. Do not force the liquid/food with a syringe. A good rule of thumb is to administer liquid/food through a gastrostomy no faster than it would take to drink it.

Following the feeding, enough water should be instilled to clear the tube. Often the amount of water will be prescribed by the healthcare provider. When not in use, the free end of the tube should be clamped shut and taped under the child's clothing. Even though the child is not eating orally, the mouth and teeth should be cleaned daily. It is not an emergency if the gastrostomy tube should slip out or become occluded. Cover the gastrostomy opening with clean gauze squares and contact the family. The child will need to go to the physician to have the tube replaced. Often a student will have a device called a "button" at the site instead of a tube.

Tracheostomy:

When normal breathing is impaired or not possible, a tracheostomy will allow breathing to bypass the nose and mouth. A tracheostomy is an incision through the neck into the trachea (windpipe). A tube is inserted to keep the incision open. A gauze dressing is usually placed around the opening of the tube next to the skin. The tube is often secured to the neck with ties.

Having a tracheostomy makes oral communication difficult, since the tracheostomy opening and tube interfere with speech. In order to speak, the opening to the tracheostomy must be momentarily covered. Do not attempt to cover the opening unless this is approved by the child's family and healthcare provider. Communication techniques such as writing, picture communication boards, or computerized speech devices should be utilized.

What You Can Do

In order to keep the airway open, mucus and secretions must be periodically removed from the tracheostomy by suctioning. This is done by inserting a small, sterile tube into the tracheostomy tube. A portable suction machine should always be available. Sterile gloves should be worn when suctioning the tracheostomy. How often suctioning is needed will depend upon the individual. A plan of care and maintenance of the tracheostomy should be developed by the family, healthcare provider, and education staff. Classroom personnel should be trained in the proper use of suctioning equipment.

Usually, children who are attending school with a tracheostomy have had the tracheostomy for several months. In the event the tracheostomy tube should fall out or be coughed out, it is likely the airway would remain open. The family should be notified immediately and the child taken to the physician to have the tube replaced. If the child is not able to breathe, or if cyanosis should develop, call Emergency Services 911. Consult with the family and the student's healthcare provider to determine what constitutes an emergency and an appropriate plan to manage the situation.

Do not expose the child with a tracheostomy to aerosol sprays, powder, or dust, including chalk dust. When the child is outside in wind or dust the tracheostomy should be loosely covered with a thin cloth or handkerchief to prevent inhalation of irritants or foreign matter. A cloth bib should be used to loosely cover the tracheostomy opening when the child is eating to prevent food from entering the airway. Always partner with the child's family and allow them to show you how things are done at home.

Ventilator:
Children who have inadequate spontaneous breathing may require mechanical ventilation. Ventilators are machines which induce inflation and deflation of the lungs. Some ventilators are portable and allow the child to have mobility and participate in classroom activities. The need for mechanical ventilation may be on a continual 24 hour/day basis, or it may be only required during sleep or for short periods during the day. Ventilator requirements and settings are determined by the child's healthcare provider.

What You Can Do

Collaborate closely with the child's family to determine the level of support that will be required. If the child is unable to do any self care, total support will be required. In cases of very complex need, skilled nursing care will be needed. Make sure all necessary supplies and equipment are readily available and that all classroom personnel are trained and competent in their use. Occlusion of the airway or mechanical failure is a medical emergency for a ventilator-dependent child. If occlusion or ventilator failure (or loss of electrical power) should occur, call Emergency Services 911. An ambu bag should always be on hand and staff should be routinely trained in its use in order to sustain the airway until emergency personnel arrive.

Cancer and Blood Disorders

Cancer is the result of cells growing out of control, developing differently in size and shape, affecting nearby cells and spreading to other places in the body. As the cancer cells grow they consume more of everything that is needed by the child or youth including nutrition. This often results in loss of strength and stamina, and weakening of the immune system allowing other illnesses to take hold and can ultimately destroy parts of the body. The most common childhood cancers are leukemia, lymphoma, and osteosarcoma (bone cancer). Treatments include medications, radiation, and surgery. Any of these approaches can be used independently or in any combination. While the treatment and cure rates are different for each type of cancer and each child with the disease, the survival rate for childhood cancer has increased dramatically over the last several decades. Now almost 80 percent of children diagnosed with cancer have a five-year survival rate. This improvement is a result of research identifying new treatments and treatment combinations. The increased rate of survival has also highlighted the need to support children and youth and their families around many different aspects of their life. Sometimes children and youth have ongoing concerns even if they have completed treatment for the initial diagnosis of cancer. Some of those concerns include other chronic health conditions, treatment side effects, surgery side effects, psychological conditions, and permanent physical or cognitive impairment.

Cancer can cause serious interference with the student's ability to learn. Cancer can result in increased risk for loss of memory or other critical school-related functions. These may be caused by the disease or the medications or treatments that are being used. Cancers of the eye, head or facial area, acute lymphoblastic leukemia, non-Hodgkin's lymphoma are diagnoses that may result in reduced school related abilities. Some chemotherapy, surgery to the brain, and radiation treatments to the head or upper spine may also interfere with learning abilities. Disfiguring surgery may result in limitations that affect school function. Anxiety and depression are also possible and can significantly interfere with learning and general participation in school.

Children and youth can also be affected by nonmalignant blood disorders like anemia, bleeding, blood clots, platelet diseases, and both red and white cell disorders. These include iron deficiency, polycythemia, sickle cell, hemolytic anemia and other rare conditions. These conditions can result in weakness and inability to tolerate physical activity, loss of stamina and ability to concentrate. They often result in the need to be away from school for numerous medical appointments.

Students may have a number of learning problems as a result of treatment or the condition itself. These include:

- Difficulty with attention to tasks;
- Memory problems;
- Difficulty with reading, writing and math;
- Poor organizational and planning abilities;
- Lower grades even when the student is exhibiting a greater amount of work;
- Poor comprehension;
- Increased frustration;
- Limited physical ability;
- Depression; and
- Anxiety.

What You Can Do

Since school is often the primary activity of children and youth, a student with a diagnosis of cancer or a blood disorder should be encouraged to return to school as soon as possible during treatment as well as post treatment. The student's family may be cautious about their child returning to school, especially if the treatment resulted in suppressed immune system functioning. The first step is to talk with the family about the condition and treatment options that are being pursued. The family and the student's oncologist or hematologist in the case of a blood disorder, can hold valuable information the school should take into consideration. If the student has been away from school for an extended period and is anticipating returning soon, the school should develop a transition plan back into school. It is important that classmates be informed about the returning student's specific diagnosis. Younger classmates may have questions like "Can I catch it?" "Are you going to die?" or "Can you still play?" Some hospitals have a school reentry program where a healthcare professional or social worker will go to the school to help with transition. When offered, these services should be accessed.

Strategies that can be helpful for students with blood disorders, cancer and post-cancer include:

- Reducing the amount of written work;
- Allowing use of a tape recorder;
- Using a computer instead of handwriting;
- Seating near the front of the room;
- Allowing a calculator in math classes; and
- Adjusting test taking requirements (extra time, oral instead of written, projects instead of the test).

As with any health condition, partner with the family and the student's health care provider to establish a plan that allows the student and family to get as close as possible to a normal routine. Cancer and blood disorders can have devastating effects on a student and family. Understanding the full scope of the effects on the family and working with them will foster an environment that supports the student to achieve in school and return to a healthy status or manage a maintenance program for an ongoing condition.

Leigh I., Miles, M., 2002, Educational Issues for children with cancer, In Pizzo, P., Poplack, D. (Eds), Principles and practice of Pediatric oncology, 4th Ed. Lippincott, William & Wilkins.
Landier, W., Educational issues following childhood cancer, 2009, CureSearch,<www.curesearch.org>
Robison, L., et al., 2009, The childhood cancer survivor study: A national cancer institute-supported resource for outcome and intervention research, Journal of clinical oncology, Vol 27, No 14, pp 2309-2318.

Diabetes

Diabetes is characterized in two ways:

- Type 1 is usually diagnosed in children and young adults. In this type, insulin is not produced by the pancreas. Insulin is a hormone that is needed to convert sugar, starches and other food into energy. Students with this diagnosis will need insulin replacement to help them to convert the sugars and starches in food to energy.
- Type 2 is more often diagnosed and results from the body's inability to produce enough insulin. In this type, the body also does not use insulin effectively. For this type of Diabetes, meal planning is the first treatment option. If this does not manage the blood glucose levels adequately, medication may be prescribed to further control the glucose levels.

Diabetes has the short term effect of cells being starved for energy and in the long term may damage eyes, kidneys, nerves, or heart. Type 1 Diabetes is more often diagnosed in children and youth. Type 2 Diabetes is diagnosed at a greater rate and can be diagnosed at any age and in any group; however, it is more common in African Americans, Latinos, Native Americans, Asian Americans/Pacific Islanders, and older populations.

Food and exercise are critical daily maintenance factors and must be adjusted with the insulin to maintain normal blood sugar. The child or youth with diabetes can do all the same things as other students. It is important for teachers and other school staff who interact with the student with diabetes to fully understand the disease and who to contact in the event of an emergency. The school staff should also work closely with the family and the student's healthcare provider on the student's treatment plan. As with most situations, every child is different when it comes to the treatment of their diabetes. It is important for school staff to learn about and support how the child and family want the individualized treatment plan implemented. Some children receive their insulin treatments at home before morning and evening meals; others need insulin more often and may need to take injections at school. Some children use a pump that allows insulin to be administered throughout the day.

A child may need to check blood sugar levels during the day. This may require using a blood glucose meter at school. Many, even young children, can check their own blood sugar levels without help, but they need to be supported by allowing them the opportunity and privacy to carry out the procedure. Other children may need more support by school staff to assure the procedure is completed and recorded appropriately. Working with the family with these procedures is important. The child and family typically have received training on how to perform the procedure and can be a valuable source of information to school staff.

Sometimes a child with diabetes and taking insulin may have low blood sugar (hypoglycemia). This may be due to not eating within a typical routine, taking too much insulin, or being more physically active. Some of the symptoms of low blood sugar may include: acting quiet and withdrawn, being stubborn or restless, tantrums or sudden rage, confusion, inappropriate emotional responses (e.g., laughter, crying), poor concentration or daydreaming, shakiness, sweatiness, headache, dizziness, pallor, or increased heart rate.

It is possible for blood sugar to go too high (hyperglycemia). This can be caused by eating more than usual, not getting enough insulin, not exercising as usual or by illness. High blood sugar can take as little as a few hours to a full day for symptoms to appear. Some of those symptoms are: nausea, vomiting, fruity odor to breath, rapid breathing, deep breathing, or sluggishness. Occasionally, unexplained, increased, or decreased blood sugar may occur.

What You Can Do

Work with the family and the student's healthcare provider to understand how diabetes is manifested in each individual student. Develop a plan with the team that includes understanding diabetes-related needs of the individual student. You should familiarize yourself with the signs and symptoms of low blood sugar, especially when it is most likely to occur. This will assist in knowing how to avoid it at school and what to do if it occurs. Identify food and snack requirements. Develop a plan of action for emergencies by coordinating with the family and the student's healthcare provider about what they want to happen regarding daily management and an emergency plan.

Work with the family and their diabetes management team to plan meals at school especially if field trips or other away-from-school activities may interrupt eating, exercise, and diabetes monitoring routines. If the child's management plan includes snacks, it is essential for the snack to be eaten every day. If something interrupts regular meals or the child does not finish a meal, an unscheduled snack may be needed later. Always inform the family about daily schedules to assure that the times of recess and physical education can be incorporated into the management plan.

If symptoms of hypoglycemia (low blood sugar) occur, do not leave the child alone. If you need assistance from school health personnel, send another child or otherwise request assistance. Follow the low blood sugar management plan that the family and the student's healthcare provider have provided. It may take several hours for a child to fully recover from an episode of low blood sugar, so accommodations may need to be made regarding full participation in the classroom schedule. Never leave a student experiencing high or low blood sugar symptoms unattended.

Tourette Syndrome

Tourette Syndrome is a neurological disorder characterized by repetitive, stereotyped, involuntary movements and vocalizations called tics. Tourette Syndrome symptoms are often first seen in childhood, usually between seven and ten years of age. More boys than girls are diagnosed with the condition. Up to one in 100 individuals in the United States are estimated to have milder symptoms of Tourette Syndrome such as chronic motor or vocal tics. The incidence of severe Tourette Syndrome in this country may be as high as 200,000. For some, the symptoms last across their lifespan. However, most students have their worst symptoms in their teens and improve as they grow into adulthood. Approximately ten percent of students with symptoms in their teen years continue to have symptoms in adulthood.

There are two categories of tics: simple or complex. Simple tics consist of sudden, brief motor movements that are associated with a few muscle groups. Eye-blinking, facial movements, shrugging or jerking movements are simple motor tics. Sniffing, grunting, throat-clearing, and other similar sounds are considered simple vocal tics. If the tics involve more than one muscle group and appear in predictable patterns, they are considered complex. For example, facial movements followed with shrugging would be considered complex. Some tics may appear to be controllable by the student like touching objects, bending, twisting, or jumping. Complex vocal tics may include words or phrases. Severe manifestations may include motor tics that can cause harm to the student or others like slapping or hitting. Severe vocal tics may include swear words or repeating the same words or phrases that others have just said.

Usually, tics first occur above the shoulders and may progress to other muscle groups in the trunk, arms, and legs as the condition progresses. The symptoms are sometimes worse than at other times. Some symptoms are initiated by excitement or stress. Others may be precipitated by environmental stimuli, like hearing others clear their throat or sniff. Some research indicates that individuals with Tourette Syndrome have differences in some areas of the brain, the connections between these areas and certain chemicals that help connections occur between these areas. There is currently no definitive information that clearly explains the cause of Tourette Syndrome.

Some students with Tourette Syndrome may also have other conditions like Attention Deficit-Hyperactivity Disorder, Obsessive Compulsive Disorder (OCD), or problems with reading, writing, and math. Anxiety or thoughts that the student may not be able to avoid, such as worries about germs, may also be present with other symptoms like hand-washing. Thoughts about disasters may be associated with rituals like counting in very specific sequence or always doing certain activities in a very specific order.

Some students may be taking medications to reduce the frequency of tics. These medications usually do not completely eliminate the presence of tics and may have side effects that are unacceptable to the student and family. Counseling or therapy may be helpful for depression and anxiety and may help the student cope with their condition. For severe, complex symptoms, the effect of electrical stimulation of specific regions of the brain is being researched. This procedure uses a battery-operated neurostimulator implanted at these specific regions in the brain.

What You Can Do

Students with Tourette Syndrome and their families need understanding and support from school and other professionals. Often the condition is misunderstood and the student may be perceived as lacking self-control. Supports should be designed around the individual student in a way that allows him/her to participate in the general school experience as fully as possible. Supports may include secluded study space, test-taking in areas away from distractions, oral tests if the student's writing ability is also affected, allowing time to de-escalate if a stressful activity has triggered an episode of tics. Other co-occurring conditions should also be considered when designing a program for a student with Tourette Syndrome. If the student is taking medication to help reduce the occurrence of tics or other conditions that are co-occurring, working closely with the family and the student's healthcare provider on consistency with taking the medications and monitoring the effectiveness of the dosage is important.

Sometimes social interactions with peers may be affected. Other students may tease and engage in behaviors that initiate onset of tics. The school should develop a plan that supports the student with Tourette Syndrome in less-structured situations (playground, cafeteria) when the potential for teasing or bullying may occur. Also, educating peers and other school professionals about the student's inability to control the tics is important.

Tourette Syndrome Fact Sheet, 2009, National Institute of Neurological Disorders, National Institutes of Health.
Tourette Syndrome, 2009, Mayo Foundation for Medical Education and Research.
What is TS, 2009, National Tourette Syndrome Association

Attention Deficit-Hyperactivity Disorder

While the impression of much of the general population is that Attention Deficit-Hyperactivity Disorder (ADHD) has been recently discovered or that its symptoms are a result of lack of personal self control, the core symptoms have been a concern of parents, healthcare providers, and educators for many years. Increased awareness and the difficulty of diagnosis have resulted in changes in name and treatment approaches. Early in the 1900s children were described as having an inability to follow rules, restlessness, inattention, and over-aroused behaviors. As early as the 1930s, medication (Benzedrine) was seen to have a positive effect on the basic symptoms of inattention, hyperactivity, and impulsivity. Early speculation considered the symptoms to result from minimal brain damage or dysfunction. Later in the 1960s, the term Hyperkinetic Impulse Disorder was used for the condition. Shortly afterwards the focus on inattention resulted in another name-shift to Attention Deficit Disorder (ADD). In the 1980s, the term ADHD was introduced with three subtypes:

- Primarily inattentive where the student appears unable to stay focused on tasks, sometimes called ADD,
- Primarily hyperactive-impulsive where the student appears jumpy, fidgety, squirmy, noisy, seemingly unable to calm down and/or making decisions without contemplating consequences, making decision unnecessarily quickly; and
- Combined type, displaying symptoms of both the previous types.

The primarily inattentive type is still diagnosed and may be referred to as ADD.

Diagnosis remains difficult even though health care professionals have been studying the conditions for some time. The primary reason for difficulty in diagnosis is that there are no biological indicators of the condition. Therefore, laboratory tests or visual studies (x-ray, magnetic resonance imaging [MRI]) cannot contribute to determining if a child has the condition. The symptoms present in ADHD differ only in quantity from typical children. That means that all children can have episodes of poor attention to tasks or be impulsive. The difference is that children with ADHD are more frequently and more consistently inattentive or impulsive and have the inability to exercise control over the behaviors. ADHD is more common in boys than in girls at a rate of almost five to one for the primarily impulsive type, and two to one for the primarily inattentive type. Boys are often seen with external hyperactive/impulsive symptoms such as aggression and over-activity. Girls often have internalizing inattentive symptoms such as underachievement and daydreaming. The male/female characterization is a generalization. Boys and girls can exhibit both or either type. Since the hyperactive/impulsive symptoms are more troublesome, particularly in schools, this generalization often results in more boys being identified earlier and more girls being under-diagnosed or diagnosed much later.

The cause of ADHD is unclear. Some of the causes often discussed in popular culture such as too much television, food allergies, poor parenting, or poor schools have not been supported by research. Research does indicate that in about 20% of children with ADHD, other diagnoses may exist and may influence the presence of the symptoms. Some of those co-occurring diagnoses are prenatal exposure to some substances (cocaine, alcohol, lead), trauma or infection. ADHD in the other 80% of children with the diagnosis is likely from multiple reasons. While it is generally accepted that there are no biological indicators for this condition, research in the area of genetics is investigating how this may play a role for some children.

It is now known that 70% to 80% of children with ADHD will continue to have the symptoms through adolescence and into adulthood. The symptoms typically change as the child ages. Often the hyperactivity decreases but the inattentive symptoms persist. Many factors influence the outcomes for a child with ADHD. Severity of symptoms, presence or absence of other conditions, social circumstances and treatment history are some of the influencers of outcomes. Usually adolescents with ADHD are less successful in school, have more driving accidents and more police encounters than do their peers. They may also achieve less in adulthood and have more problems with relationships. It is important to remember that ADHD is a chronic illness with no cure. However, ADHD symptoms can be managed with medications and behavioral management tools.

What You Can Do

In the early years, students with ADHD may need assistance with time management to help them be better organized. Start with large calendars, indicating when days are completed. Continue with noting hours during the day and then on to the number of minutes needed to complete tasks. Indicate on the monthly, weekly, and daily calendars, activities that should be accomplished during that time period. Each student will need additional supports to assist with on-task behaviors, activity completion, and distraction management. Stickers and other token rewards may also be helpful.

Assignment notebooks for students that are clearly marked, in a size that is not easily lost, and for which a consistent routine for management is developed are particularly useful as the student learns to assume more responsibility. Use color coding to help organize materials and assignment directions. A daily communication log between home and school will support student, family and teacher partnership. As students mature in the elementary years, daily planners to record homework assignments, tests, quizzes and other school activities will continue to support personal responsibility. Students will need to be taught how to use this support. Prompt the student to write assignments with due dates, materials needed, and any other tools necessary for completion as the assignment is given. A well-organized backpack or book bag with a place for all items the student will need during the day is always helpful. Support the student with techniques that establish habits to check all storage compartments in the backpack before they leave for another location in school or before leaving for home. Establish a program that supports the student to check in with someone in the morning to get the day started well. Also, provide a schedule that supports the student checking out with a specific person in the afternoon.

In the upper years, planners are also useful. Either paper or electronic planners that fit in pockets or purses will help the student appear more typical. If lockers are used in school, a student with ADHD may need assistance with organizing the space so that materials can be located during class changing times. Color coding can also help with the locker. Readily available organization shelves as well as magnetic pencil and pen holders can often be used in the locker. Use the locker door to display daily and weekly schedules. Many other office organizational tools like address books or software programs may provide other organizational supports.

Environmental controls also produce success for students with ADHD. Provide a quiet area free of frequent distractions for students to work independently. Large group activities can be challenging, however, small groups of two to three can work. Write assignments clearly and concisely for all students. Help the student with ADHD develop habits that support frequent checking with the assignment board.

If students are on medications, the prescribing physician may ask the teacher to log impulsivity and attention information to help assess the utility of the level of dosage or different drug options. Close collaboration with the student's healthcare provider to develop the frequency and type of behaviors to observe and report will be important. These logs may also include side effects like loss of appetite or sleepiness. Medications may also need to be administered at school. Should this occur, the individualized education program should include what supports and documentation are necessary to assure the medications are taken at the appropriate time and in the prescribed dosage.

As with any other condition, work with parents to develop supports and accommodations that are consistent across all settings. Students with ADHD will have difficulty changing processes like moving from one location to another. Coordinating with all school personnel to implement modifications and adaptations consistently is important.

Brandis, J, 2007, Other health impairment registry training
Lock, T., Worley, K., Wolraich, M., 2008, Attention-deficit/hyperactivity disorder in Developmental and behavioral pediatrics: Evidence and practice, Mosby Elsevier, Philadelphia, PA.

Other Health Impairment

Section IV: Individualized Education Programs

Present Levels of Academic Achievement and Functional Performance

Health issues can be identified as part of the information in the Individualized Educational Program's Present Levels of Academic Achievement and Functional Performance section. This health information should be gathered from the student and their family, other team members, and from the student's healthcare providers. Often these healthcare providers include the primary care physician and a number of other health care specialists. The student's family can help focus your inquiries to the specific healthcare provider that is considered the lead clinician at any point in time. The lead clinician may change over time, depending on the specific condition the student may have. Health conditions may influence the student's performance across many education related domains. The statements within the Present Levels of Academic Achievement and Functional Performance section should be clear, descriptive statements of how the child is performing in specific areas including strengths, interests and needs. Any health concerns, limitations or needs should be included in the Present Levels of Academic Achievement and Functional Performance section when they affect the student's involvement and progress in school. Any accommodations, adaptation and support needs should also be described in this section. Some examples of Present Levels of Academic Achievement and Functional Performance section statements are:

- *"John currently cannot tell caregivers or others how to transfer him, making him reliant on his educational assistant throughout the day."*

- "Sarah knows which medications she takes. She needs reminders during lunch and afternoon recess on when to take them."
- "Tim easily becomes dehydrated, causing him to become unfocused and disoriented. Tim is just beginning to recognize when he's getting dehydrated and needs a water break."
- Joe's plan of care includes a protocol if he has trach problems. He needs reminders to bring the care plan in his backpack every day."

Transition-age students should have needs described in Present Levels of Academic Achievement and Functional Performance sections that are closely aligned with post-school outcomes. Transition plans must be included in the individualized education program at age fourteen. Areas to consider when identifying needs for youth served under the Other Health Impairment category include job training and employment, higher education, independent living, leisure, and recreation. Independence with personal healthcare management becomes more important as the student approaches adulthood. School programs should include supports to students with management of their health status as part of the transition plan. Examples of current needs for inclusion in Present Levels of Academic Achievement and Functional Performance sections for the transition age student are:

- "Sam is unsure how his health insurance changes when he turns 21 and moves away from home."
- "Jane has not located an adult healthcare provider."
- "Joe does not know how to call in a prescription for refills."
- "Paul needs to learn how medical side effects could affect his work performance, and stamina for leisure activities."

IEP Goals

Goals are written to directly relate to the needs expressed in the Present Levels of Academic Achievement and Functional Performance sections and should generally address what the student can reasonably be expected to accomplish in about a year. For those students working toward alternate standards, the goal should also include short-term objectives/benchmarks that have greater specificity and can be reached in shorter time frames and that clearly indicate success when they are met. Accomplishing health-related goals and short-term objectives/benchmarks may require support from an array of team members. Sometimes goals are written for the student with support from school and home. In addition to more typical team members such as occupational therapists, physical therapists, general and special education teachers, nurses, social workers or health aides may need to be involved in delivery of the individualized education program. At other times, health-related activities or procedures written into the individualized education program are performed by a registered nurse or other healthcare provider with specialized training. School support staff performing healthcare procedures may need supports such as training and technical assistance provided by more specialized nonschool healthcare providers. These supports should also be included in the individualized education program. Partnering with the student and family and their healthcare providers will produce a school program that supports the student with an ongoing health condition achieve at their potential. Examples of health-related short-term goals are:

- *Bob will monitor his urine output for quantity and color to assess for dehydration daily with 80% accuracy.*

- *Sarah will develop an increased awareness of the early warning signs of her migraines and will seek appropriate treatment by requesting to see the school nurse every time she experiences a migraine.*

- *Mary will be able to tell school staff in all settings about her peanut allergy without prompts so she can participate across community settings without direct adult supervision with 80% accuracy.*

Supports and Services

Once the goals and short-term objectives/benchmarks are written, statements of supports and services delivered to, or for the student should be developed. These supports and services can include program changes or help for school staff who will be working with the student or both. They should be developed to assure that the student moves steadily toward accomplishing the individualized education program goals, is a part of the general education curriculum, and participates in any school activities that other students are involved in. Supports and services can include school health services, as well as related services such as transportation, occupational and physical therapy services, speech/language services, modified physical education, counseling and others. Some health-related goals can be carried out by special education paraprofessionals, such as learning how to self-catheterize or learning how to monitor blood sugar levels, but the paraprofessional should be provided training and supervision by a qualified health professional such as a registered nurse. Some families have high skill levels with health procedures and can provide the school staff with training. However, it is important for the school to be able to determine when the family's skill levels are appropriate for training others. Training and healthcare supervision for school staff should be included in the individualized education program as a necessary support.

Accommodations and Modifications

Chronic health conditions vary widely across children and youth as well as over time. Accommodations and modifications will necessarily need to be adapted to the individual student and how that student's condition is presenting at any given point in time. This means that some students may need differing levels of accommodations as their condition improves or worsens. A review of the needs of a student may need to occur more than yearly and the individualized education program may need to have a range of options for the student. Simple accommodations like more transition time between classes or a special location in the classroom may be all that is needed. Other students may need home visits at times or medical procedures provided at school. Below is a list of accommodations. This list does not include all possibilities. It, however, is intended to provide possibilities and a starting point for developing a plan to support the student and school success.

Time Adjustment:

- Allow extra time to complete assignments;
- Provide additional teacher/student one-on-one conferences during the day;
- Assigning class and homework in shorter segments to reduce sense of being overwhelmed;
- Break tests into smaller segments and allow time for rest between segments;
- Shortened days (start late or end early); and
- Exempt student from mandatory absence policies.

Educational:

- Provide peer tutoring;
- Allow tape recorders or peer note takers;
- Provide study guides;
- Pair oral directions with written directions;
- Simplify complex directions;
- Provide study-skills training;
- Shorten assignments;
- Do not grade handwriting;
- Allow computer-printed assignments;
- Do not require cursive or manuscript handwriting;
- Allow different options for assignments;
- Provide a second set of textbooks for home use; and
- Structure transition and free time (recess, lunch, etc.).

Classroom:

- Seating near teacher, in the front of the room, back of the room or other areas of the room where instruction occurs;
- Seating near a study buddy/friend/mentor;
- Teacher standing near the student when instructions are delivered;
- Allowing increased distance between desks to allow for movement and stretching;

- Controlling distracting auditory and visual stimuli; and
- Allowing opportunities to be out of seat for stretching or other movement necessary for management of the student's condition.

School Work:

- Large print, videos, organizational outlines;
- Key points listed on the chalkboard;
- Confirm with the student that directions are understood;
- Provide written outlines;
- Underline, highlight key points;
- Avoid long tests by giving short quizzes;
- Break work into small segments;
- Reduce homework assignments;
- Send homework assignments home with clear, concise directions;
- Do not require speed and accuracy in the same assignment;
- Give tests orally;
- Substitute projects for tests;
- Do not use computer scored tests; and
- Allow questions to be read to the student.

Home/School Coordination:

- Provide extra textbooks for home;
- Organize peer support to transition between classes and from school to home;
- Provide specialized transportation;
- Establish multiple methods of communication with home (telephone, email, notes, etc.);
- Compile progress reports from other teachers for delivery to parents; and
- Share daily/weekly schedules with parents.

Each student's accommodations will need to be designed based on their health condition and how that condition is manifested at any given point. The

Accommodation options listed above will need to be expanded based on local school differences and differences across conditions and students. Accommodations may have to be adjusted frequently as the condition improves or progresses. Frequent hospitalizations resulting in prolonged absences may require significant adjustments in expectations. It may be necessary to convene the Individualized Education Program team meeting more frequently than for other students. If the student is experiencing an intensive health event, the family will likely be unable to meet to discuss school issues. Establishing a strong trusting relationship with the family early in the process will support ongoing communication and collaboration during difficult health events.

Other Health Impairment Services During Transition

At age fourteen a transition plan must be included in the individualized education program. Students with chronic health conditions served through the Other Health Impairment category should also have a transition plan. Careful attention should be paid to youth understanding and assuming increased responsibility for management of their health condition. Support for acquiring these skills can be included in the student's transition plan. Students assuming more responsibility for their care of their health can be anxiety provoking for all team members, especially the student and family, particularly if the health condition is complex and the student's health is fragile. During transition planning, collaboration with non-school service providers is very important. As the school plans for healthcare transition, the student's primary healthcare clinician and specialty providers should also be supporting the student as they assume greater responsibility. Making the two plans compatible is critical. This should be planned carefully with the family and the student. Healthcare transition issues to consider may include how the student health status may affect job choices, postsecondary education, independent living and leisure and recreation. For example, if a student's health condition includes a suppressed immune system, some vocations that expose workers to others who may be ill is not a good choice. If a student has a seizure disorder and is prohibited from getting a driver's license, transportation to higher education facilities and jobs may be challenging.

Examples of health related transition goals are:

- *I will learn two or three side effects of my medication and learn when to report any changes in side effects or new symptoms to my doctor.*
- *I (school personnel) will meet with a health-benefits counselor at least once during the first semester to learn about power of attorney for health care so that the student's parents can remain involved in his/her health care decision after he/she turns eighteen.*
- *I will learn the telephone number and rehearse a script to be able to call in my own prescription refills this semester.*

Section V: Collaborating with Community Resources

To effectively work with other community programs and to coordinate services and supports, school personnel need to understand how those other services are similar to, but more importantly, different from education. Since the student served through the Other Health Impairment category receives healthcare services from multiple healthcare providers, collaborating with primary and specialty health care is crucial. For healthcare providers, there are differences in eligibility, scope of services, and frequency of service provision and location of service delivery. A different funding model is also present. Most doctors, whether they are in a practice alone or with a group of other doctors, are small businesses. This means that they must provide care to patients and get reimbursed for that care from insurance providers or from the patient directly. This requires serving enough patients to generate enough money to cover all the costs of the practice. Activities like attending individualized education program planning meetings, talking with school personnel or writing explanations of healthcare procedures are non-billable or effectively volunteer time. There are several factors that influence collaboration across service streams: awareness, cultural differences, communication, and collaboration processes.

Awareness

The first step is knowing about other community resources. Understanding the other system's perspective and purpose is important at this step. An awareness of common goals and different approaches, histories, and cultures will help create an understanding of how to work with the system to better support students with chronic health conditions. Families can help with this step. Ask parents what other systems they use to support their child's health. Knowing the family doctor and other specialty doctors will help school personnel understand the complexity of the child's condition. All of these service providers share the same commitment to their clients and patients as do school personnel. This is the core similarity on which collaboration can be built. Request permission to access information from and share education program information with these service providers.

Cultural Differences

Schools and other publicly funded programs have much in common, so this discussion will not focus on publicly funded services. Students with chronic health conditions are extensively engaged with heathcare providers, therefore an emphasis will be placed on discussing the health delivery system here. Unlike public schools and other publicly funded programs, there is no mandate or entitlement to health care. Public education is organized around bureaucratic structures, including geographic area, level of government, and agency chain of responsibility. The healthcare system is organized around levels of specialization of knowledge and services. That means that general health care is provided by the family doctor, but the patient will likely go to one or more doctors that specialize in a specific condition or system of the body. It is likely that students being served through the Other Health Impairment category will routinely see a healthcare specialist. In health care and medicine, scientific inquiry and research serve as the core of practice. Decision-making is based on making a clear, reliable diagnosis. Reaching a diagnosis relies on a problem-solving approach, often ruling out one or more possible diagnoses before settling on the specific one for an individual patient. This contrasts with schools in that theoretical models determine service approach and program. Assessment focuses on identifying strengths and addressing needs. The amount and type of service is usually bureaucratically established criteria and level of need. Primary care doctors see themselves as serving the whole person and may view other types of service providers, including school personnel, as specializing in only one aspect of the person. Healthcare providers may not know that a child could be eligible for special education services based on having a health condition that affects the student's learning.

Language is also another area where differences occur. Doctors use medical terminology that can be highly technical and descriptive, whereas, schools have their own jargon that can be difficult for other service providers to understand. These differences call for a concerted effort by all people to bridge these differences in order to engage in collaboration. Some strategies that contribute to improving an understanding of a different profession's culture include reflecting back on successful interactions. Think about what made these interactions work and build on them. Appreciate the time constraints of health professionals. Time can be a major barrier to connecting with the healthcare system. Talk with the parents of the students you serve. Ask them about their experiences and the healthcare professionals they consult.

Communication

For schools, communication often is face-to-face with parents. This communication is usually required by federal legislation and corresponding policies and procedures developed at the state level. Healthcare providers often communicate through brief telephone calls, dictated letters, or consult forms. These different styles may result in miscommunication or limited opportunity to share information. Doctors talk with their focus on diagnosis, prognosis, and treatment. Schools share information about strengths, needs, eligibility, and service plans. In order for schools to communicate with healthcare providers, school professionals need a good understanding of how doctors typically communicate with each other and try to match that style. Talking to a doctor's office staff is a good way to start a relationship with the practice. Ask questions about what is the best way to share information. Let the practice know that you are asking these questions to improve the supports you are providing to your students with chronic health conditions. Always ask when the best time to speak with the doctor's staff and the doctor might be. Be specific about what you need and why you need it. The key is understanding when the staff is busy and how they prefer to communicate. Ask how they prefer to receive information from schools. Always follow-through on commitments. Developing long-lasting relationships is very important.

Collaboration Processes

Working together with providers from other service systems is the last factor to develop and maintain. Collaboration can take place at several levels. The primary level is around an individual student with a specific condition and their healthcare providers. This can lead to a different level of collaboration, where both school professionals and healthcare professionals utilize each other's expertise in a more general way to better serve all their students and patients. This level is important to establish and maintain over time. An ongoing relationship with other service providers provides insight into the full community of providers that families utilize.

Bronheim, S., Tonniges, T., (2004). Strengthening the community system of Care for Children and Youth with special healthcare Needs and their Families: Collaboration Between Health Care and Community Service Systems, Georgetown University Center for Child and Human Development, Washington, DC.

Section VI: Collaborating with Families

Families of Children and Youth with Chronic Health Conditions

Families of children and youth with chronic health conditions experience similar stressors, as do families with children and youth with disabilities. These families also experience the day-to-day demands experienced by all families. The influence of chronic health management for a child can take a significant toll. How these families adapt to the increased demands varies with the resiliency of the family unit and the individual members of the family. Research has shown that there are more divorces and single parent families on the lower end of the annual income scale and as financial costs increase due to having a child with chronic health conditions occurs. In the 2009-2010 National Survey of Children with Special Health Care Needs, almost 14.3% of Illinois families with children and youth with chronic healthcare conditions were at or below the federal poverty level of ($22,050 for a family of four). (Refer to following page of The National Survey of Children with Special Health Care Needs Chartbook 2009-2010; Illinois.) Other reviews of the status of families with children and youth with chronic health conditions indicate that many (almost one-fourth) of these families are headed by single parents. The capacity of these families to engage with schools and other service providers is often compromised by these bleak circumstances of family status. However, these conditions are not constant. They change over time. It is important to consider the whole family and how the condition of their child influences their ability to partner effectively with school personnel and programs.

Illinois

Estimated number of CSHCN: 452,574

All statistics are based on parental reports

Prevalence of CSHCN	State %	National %
Percent of children who have special health care needs	**14.3**	15.1
Age		
0–5 years	**9.2**	9.3
6–11 years	**16.3**	17.7
12–17 years	**17.4**	18.4
Sex		
Male	**16.2**	17.4
Female	**12.3**	12.7
Poverty Level		
0–99% FPL	**14.3**	16.0
100–199% FPL	**13.6**	15.4
200–399% FPL	**15.9**	14.5
400% FPL or more	**14.1**	14.7
Hispanic Origin and Race		
Non-Hispanic	**15.1**	16.2
White	**15.1**	16.3
Black	**16.5**	17.5
Asian	*	8.0
American Indian/ Alaska Native	*	13.5
Native Hawaiian/ Pacific Islander	*	12.3
Multiple races	*	17.9
Hispanic	**11.7**	11.2
Spanish language household	**8.1**	8.2
English language household	**17.1**	14.4

**Due to the small size of this group in the State population, data have been suppressed to protect respondents' confidentiality.*

Indicator	State %	National %
Child Health		
CSHCN whose conditions consistently affect their activities, often a great deal	**27.3**	27.1
CSHCN with 11 or more days of school absences due to illness	**16.3**	15.5
Core System Outcomes		
CSHCN whose families partner in decision making regarding their child's health	**71.1**	70.3
CSHCN receive coordinated, ongoing, comprehensive care within a medical home	**44.5**	43.0
CSHCN with a usual source of care when sick	**85.9**	90.5
CSHCN with a personal doctor or nurse	**91.4**	93.1
CSHCN who receive family-centered care	**66.8**	64.6
Families of CSHCN have adequate private and/or public insurance to pay for the needed services	**62.2**	60.6
CSHCN with insurance for the entire past year	**96.8**	90.7
Currently insured CSHCN whose insurance is adequate	**63.8**	65.7
Children are screened early and continuously for special health care needs	**81.3**	78.6
Community-based services are organized so families can use them easily	**64.6**	65.1
CSHCN whose families had no difficulties or delays receiving services	**66.1**	65.9
CSHCN whose families are sometimes or never frustrated in obtaining services	**89.4**	90.2
Youth with special health care needs receive the services necessary to make transitions to adult health care	**45.3**	40.0
Impact on the Family		
CSHCN whose families pay $1,000 or more out of pocket in medical expenses per year for the child	**22.6**	22.1
CSHCN whose conditions cause financial problems for the family	**20.6**	21.6
CSHCN whose families spend 11 or more hours per week providing or coordinating the child's health care	**10.7**	13.1
CSHCN whose conditions cause family members to cut back or stop working	**23.7**	25.0
CSHCN whose parents avoided changing jobs to maintain their child's health insurance	**16.4**	17.7

Children and Youth with Chronic Health Conditions

Children and youth with chronic health conditions may appear as capable as the typical student with no observable indicators of their condition. Others may be easily identifiable. Some of their impairments may be life threatening while others may interfere minimally with their ability to function in the school environment. A student's health condition requires them to learn new skills and to assume very different responsibilities than may have been previously required in the past. It may be difficult to move from one part of the school building to another, placing increased demands on the focus and physical strengths of the student. Pain interferes with all the skills students need to successfully learn. These students may also need specialized supports that take time out of the school day to accomplish. These and other factors are the reason these children and youth need accommodations and modifications in the learning environment. As is true with the families of these students, the effects of their health condition can change over time. Therefore, the program plan will likely change from year-to-year or change may be needed on much shorter intervals. School personnel and families must establish trusting partnerships to be ready to adequately support these children and youth at school.

What Families Want

Families are the experts on their children. They know their needs and how different services may or may not be received by their children. They want to feel comfortable where services are provided and with those providing the service. They want to know their child is safe. They should expect to be heard and respected. Programs that have the most successful relationships with the families they service put family centered care into action. These programs believe that all families have strengths and the capacity to build on those strengths. Programs and families should want to partner with professionals to get the best array of services for the child. Families want to share the information they have about their child and their child's condition. They want to hear the professional's perspective and expertise about their child's condition and how the school can support their child. Decisions must be made jointly, relying heavily on both the expertise of the family and the professional. Supports and services should be provided for the child, not in isolation, but within the context of the family. Finally, families want to be a part of the evaluation process. They want to be a part of determining if a specific approach or an overall program is meeting their needs, as it was planned to do.

Child and Adolescent Health Measurement Initiative. 2009-2010 National Survey of Children with Special Health Care Needs, Data Resource Center for Child and Adolescent health website.

Other Health Impairment

Section VII. Forms and Sample Letters

The following documents may assist with management of some of the processes that schools may encounter while serving students through the Other Health Impairment category:

- Behavior Observation Summary – provides a way to document observed behaviors as the student participates in various school activities. It uses an anecdotal format to allow for documentation of known and not previously observed behaviors.
- Baseline Behavior Chart – provides an organized way to document previously identified behaviors. The form is organized with potential behaviors and blank lines for behaviors unique to the student being observed. The form is intended for a single observation period. The form should be used to document the occurrence of behaviors objectively, thereby excluding subjective perceptions.
- Baseline Behavior Summary – This form is used to compile up to twenty single observations using the Baseline Behavior Chart. The form, when completed, will provide a way to assess behaviors over time allowing analysis of peak behavior periods and low behavior periods.
- Daily Progress Note – This form can be used to facilitate communication between school and home about the student's daily performance.
- Medical Summary – This form is used to document the status of a student's health and healthcare interventions. The form provides places to record baseline health information that may be useful as the school manages healthcare processes. The form should be completed by the student's

parents and/or healthcare provider. For students whose health status changes over time, the form may need to be updated routinely.

- Sample Letter to Healthcare Provider – This document provides some suggested language with which school personnel may begin communication with a student's healthcare provider.
- Oklahoma State Department of Education Form 12 Medical Report – This document can be sent to the student's healthcare providers to acquire information about the student's healthcare status. The form can be expanded to gain additional relevant information about the student and their condition.

Behavior Observation Summary

Student: ____________________ Grade: ________________ Date: ______
School: ____________________ Class: ________________ Hour: ______
Observer: ___________________ Time: ______________________________

Observations:

Follow-Up/Plan of Action:

Baseline Behavior Chart

Student: ______________________ Grade: ____________________ Date: ______
School: ______________________ Class: ____________________ Hour: ______
Observer: _____________________ Time: ____________ Teacher: ____________

Observed Behavior	**Number of Times Behavior Observed**	**Time of Observation & Totals**
Making Noises		
Calling Out		
Interrupting Others		
Talking Back		
Self Directed Put Downs		
Off Task		
Physical Contact		
Failure to Follow Instructions		
Inappropriate Gestures		
Profanity		
Destruction of Property		

Baseline Behavior Report

Student: ____________________ Grade: ________________ Date: _______
School: _____________________ Class: ________________ Hour: _______
Observer: ___________________ Time: __________ Teacher: __________

Behaviors Observed	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Noises																				
Calling Out																				
Interrupting																				
Talking Back																				
Put Downs																				
Off Task																				
Physical Contact																				
Follow Instructions																				
Gestures																				
Profanity																				
Destruction of Property																				

Daily Progress Note

Student: ______________________________________ Date: _____________

Teacher: ____

PARENTS: Please review, sign, and return to school.

My school work today was…

_____ Completely finished. No homework!

_____ Partially finished. I have homework due.

_____ No completed work in any subject. I have a lot of work.

Homework that is due:

My behavior in school today was …

____ Extremely Good! My teacher is proud of me!

____ Satisfactory. I did fine today.

____ Inappropriate. I had problems with ___________________________

____

____

_________________________ _____________________________

Teacher Signature Parent Signature

Message for teacher:

MEDICAL SUMMARY

Patient Name ______________________________ **DOB** ____________________
Parent's Name _____________________________ **Phone** ___________________
Updated __________________________________ **Insurance** ______________
Principal Diagnosis ____
Secondary Diagnosis ____
Primary Physician: _______________________ **Phone** __________________
Allergies____

Health Conditions	**Unique Symptoms**

Specialists	**Phone Number**

Medications / Dose	**Medications / Dose**

If This Happens	**Do This**

Support Services

Service	Frequency	Contact Information
Home Care		
Physical Therapy/ Occupational Therapy		
Durable Medical Equipment		
School/Child Care/ Early Intervention		
Other		

History:

The following steps are to be followed when ____________ is ill:

In case of emergency, the following steps are to be taken:

Other issues to monitor:

Sample Letter to Health Care Provider

Use this sample letter as a starting point for writing to your student's health care provider. Make the language used reflect your need to communicate and the unique issues presented by the student you are discussing.

Dear Dr. ____________________

____________________ is a student at ______________________ and is being considered for services *(or is served)* through the Other Health Impairment category. These services include accommodations, modifications and supports of the typical services offered to all students. As ______________ teacher, I want to be as well informed about his/her health condition as possible and to assure that my classroom and the school's services meet health safety that are unique to _____________. I also want to collaborate with you and ______________ other health care providers by sharing relevant information from the school setting to you.

The enclosed release of information signed by _____________ parents requests specific health information. ______________ parents believe this information will help me support him/her at school and better understand his/her health status. If there is information, other than that requested that you believe I should have, please request from ________________ parents permission to send it to me.

If you need specific information about _________________ school experience, please contact me at ________________________. It is easier to reach me during the following hours. However, I will return your call if this is inconvenient for you.

Thank you,

MEDICAL REPORT

NAME OF CHILD: ______________________________ STUDENT ID: __________
FIRST MIDDLE LAST

BIRTHDATE: __________ GRADE ______ AGE ______ DATE: __________
MONTH/DAY/YEAR

PARENT(S): ____

PHONE: (WORK) __________ (HOME) __________ (OTHER) ______________

HOME ADDRESS: ______________________________ DISTRICT/AGENCY: ________
STREET ADDRESS/P.0. BOX CITY STATE ZIP

TO BE COMPLETED BY THE SCHOOL

REFERRAL Date __________ School Contact Person ________________ Phone ________

Medical concerns about this child are as follows:

At school

____

____

____

At home

____

____

____

NOTE: Consent for Release of Confidential Information with parent signature, is required.

TO BE COMPLETED BY A LICENSED MEDICAL DOCTOR, DOCTOR OF OSTEOPHY, OR ADVANCED REGISTERED NURSE PRACTITIONER (ARNP)

Information in the following areas would be helpful to the school and parents in planning for the child's educational needs. Please respond as appropriate, including any applicable medical diagnoses.

General health:

Motor functioning:

Neurological findings:

Allergies:

NAME OF CHILD: ______________________________ STUDENT ID: ____________

FIRST MIDDLE LAST

Dietary considerations:

Vision (attach eye report):

Hearing:

Medication, including purpose:

Other pertinent information:

Please indicate ways in which any of the above may adversely affect behavior.

Is further medical evaluation or treatment planned for any specific area?

In what ways may your medical findings affect the school's educational or behavioral planning?

In what ways can school personnel facilitate ongoing communication with you?

If the child is involved in the **Systems of Care** program, please describe.

This information will be maintained in accordance with the Family Educational Rights and Privacy Act (34 CFR Part 99) and Individuals with Disabilities Education Act (IDEA).

Medical or epidemiological information or records which identify any person as having a communicable or venereal disease (such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus [also know as AIDS]) shall be strictly classified as confidential pursuant to Title 63 O.S.§ 502

Physician's or ARNP's name address, and telephone number (typed or stamped)	______________________________ Physician's/ARNP's Signature ______________________________ Date

West, L., 2007, Other Health Impairment: Educational Applications, Oklahoma Teacher Registry, Oklahoma State Department of Education.

Portable Medical Summary, 2009, Healthy and Ready to Work National Center