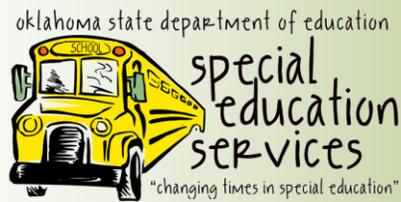


Other Health Impairment

A Guide for Supporting Children and Youth Served in Public Schools

February 2010



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Other Health Impairment

A Guide for Supporting Children and Youth Served in Public Schools

This guide was developed to support families, teachers and school administrators as they serve children and youth with health conditions that are affecting their educational performance. It provides information to increase understanding of eligibility criteria, appropriate supports and services and health conditions that may influence student achievement.

Other Health Impairment: A Guide for Supporting Children and Youth in Public Schools was developed in part with information compiled by Debbie Berry, Joyce Brandis, Chris Francl, Mary Beth Logue, Luan West, Dorothy Wortman and Louis Worley for dissemination during the Other Health Impairment Registry Training and through an Oklahoma State Department of Education, Special Education Services contract for Registry Training with Chris Francl. This publication was funded using Individuals with Disabilities Education Act (IDEA) federal funds.



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Other Health Impairment

Section I: Introduction

Purpose

Over the last decades, improvements in healthcare delivery, nutrition, and living conditions have resulted in increased numbers of children surviving life-threatening circumstances at birth. Other children acquire complex health conditions that may be short in duration or become a lifelong management issue. While many of these children's initial conditions may have been resolved, they are often left with ongoing complications that have the potential to influence their success in school. These health conditions can range from children with Attention Deficit-Hyperactivity Disorder (ADHD), to children who are quite fragile. These health conditions fall into two broad categories: 1) neurological conditions (i.e., Tourette Syndrome) which appear to be more like other special education qualifying conditions, and 2) other conditions which are more often found in the health care arena.

Schools are expected to understand the influence these conditions have on learning and to provide education to these children and youth. Teachers need information and support to meet this need. This manual is designed as a resource to provide teachers with the following:

- Information on chronic health conditions;
- Support with decision making on how and when to serve a child within the category of Other Health Impairment; and
- Information on how to accommodate the many challenges these children and youth encounter daily and how to collaborate with families and their health care providers.

Chronic health conditions are typically characterized as those lasting more than a year and with severity sufficient enough to create some limitations in usual activity. Estimates of the number of children and youth with chronic health conditions is as low as 10% to as much as 30% depending on what is included in the general category of chronic conditions. Examples of chronic health conditions include asthma, cystic fibrosis, congenital heart disease, diabetes mellitus, attention deficit-hyperactivity disorder and others. In Oklahoma, the nature and extent of poverty has an overarching impact on the health, development and well being of all children and youth. The expanding capacity of healthcare delivery to treat and sustain individuals with life-threatening diagnosis in recent decades also contributes to the number of children and youth in our schools with chronic health conditions. Children and youth with chronic health conditions may experience limitations in some activities, frequent pain or discomfort, more hospitalizations, outpatient visits, and medical treatments than those with more typical health. Those with severe conditions may be unable at times to participate in school and other peer activities.

Clay, D., 2004. Helping schoolchildren with chronic health conditions: A practical guide. The Guilford Press. New York, NY.
The Merck Manual, 2005. Children with chronic health conditions. www.merck.com
Stiller C. Epidemiology of cancer in adolescents. Medical Pediatrics Oncology. 2002;39:149-155
Newacheck PW, Rising JP, Kim SE. Children at risk for special health care needs. Pediatrics. 2006;118:334-342.

Competencies

- Foundation knowledge regarding conditions that are addressed within the Other Health Impairment category;
- Strategies for communicating with the student's medical provider(s);
- Decision-making skills regarding when a child with a chronic health condition needs special education;
- Strategies for serving students in the special education classroom;
- Knowledge of state and local resources; and
- Knowledge about how to work more supportively and cooperatively with families.

Overview

This handbook is intended to provide awareness and guidance during placement decisions, individualized program planning and implementation and support of students with chronic health conditions and their families. It is designed primarily for classroom teachers providing services within the Other Health Impairment category. Other school personnel including administrators, counselors, psychologists, paraprofessionals, students, as well as their families may also find the information useful. The conditions described do not include all possible health conditions, but are likely the most common. Oklahoma policies regarding Other Health Impairment, individualized education program guidance, family support, forms, letters, and resources for further learning are included.

Credits/Acknowledgments

This handbook was developed through an Oklahoma State Department of Education, Special Education Services, contract for Teacher Registry training. The conceptual framework was based on the materials developed through the Other Health Impairment Registry training by the multiple presenters associated with the training since its beginning. Chris Francl and Louis Worley worked closely to compile and organize the information from multiple sources.



Other Health Impairment

Section II: Definition

The Individuals with Disabilities Education Act (IDEA) is a federal law ensuring services to children and youth with disabilities. The IDEA governs how states and public agencies provide early intervention, special education and related services to eligible infants, toddlers, children and youth with disabilities. Infants and toddlers with disabilities (birth to three) and their families receive early intervention services under the IDEA Part C. Children and youth (aged 3 to 22) receive special education and related services under the IDEA Part B.

The IDEA Part B definition in 34 CFR 300.8 states *“Other Health Impairment means having limited strength, vitality or alertness, including a heightened alertness to environmental stimuli, that results in limited alertness with respect to the education environment, that – (i) 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, sickle cell anemia, and Tourette Syndrome; and (ii) Adversely affects a child’s educational performance.”*

The Policies and Procedures for Special Education in Oklahoma manual provides additional guidance on the definition of other health impairment, evaluation, and eligibility criteria. This document is available through the Oklahoma State Department of Education, Special Education Services, 2500 North Lincoln Boulevard, Suite 412, Oklahoma City, Oklahoma 73105-4599, or the manual may be viewed and downloaded at <www.sde.state.ok.us>. An excerpt on other health impairment from the Policies and Procedures for Special Education in Oklahoma manual follows:

Components of a Comprehensive Evaluation

- *Medical information*
- *Other information as relevant to the child's health condition*
- *Academic/achievement/developmental*

Medical information from a licensed physician or an Advanced Registered Nurse Practitioner (ARNP) is required providing any relevant medical findings, health problems, medication, and any information deemed necessary for determining eligibility and/or planning the child's educational program. The Medical Report (OSDE Form 12) may be utilized. Health information from the school nurse may also be useful.

Individual evaluation of the child's specific educational needs and present levels of academic and/or developmental functioning is also required. Present levels of performance in the general education curriculum, academic performance, achievement, or age appropriate activities are important information the group must document and consider. Readiness and developmental activities would be appropriate for children in the early years.

Further evaluation procedures may be necessary for the child's specific health conditions(s) to determine whether the child has a disability which requires special education and related services and the impact of the specific health condition on the child's educational needs.

*Attention deficit disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD) may require psychoeducational, 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** [emphasis added] 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).

Key Eligibility Indicators

Limited strength, vitality, or alertness, including a heightened alertness to environmental stimuli (resulting in limited alertness with respect to the educational environment) due to chronic or acute health condition which adversely affects educational performance are key eligibility indicators. Lack of appropriate instruction in reading, including the essential components of reading instruction, mathematics, or IEP must not be the determining factor. Note: In determining eligibility for “other health impairment,” when the suspected condition is ADD or ADHD, the Diagnostic and Statistical Manual of Mental Disorders (DSM), most current edition, or Professional Group for Attention and Related Disorders (PGARD) criteria, and definitions published in the most recent Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD) Educators Manual may be useful to the group.

Oklahoma State Department of Education, Policies and Procedures for Special Education in Oklahoma Manual, 2007

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

Simple partial seizures 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.

Complex partial seizures 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.

Generalized seizures 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](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 (Benedrine) 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.

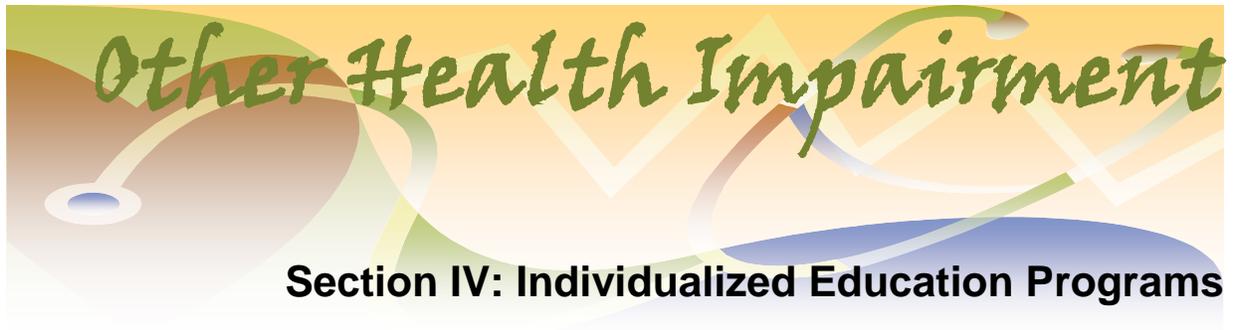
If students are on medications, the prescribing physician may ask the teacher to log impulsivity and attention information to help assess the utility of the level of dosage or different drug options. Close collaboration with the student's healthcare provider to develop the frequency and type of behaviors 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.



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 at 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 section that are closely aligned with post-school outcomes. In Oklahoma, 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 section 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 section 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 in Oklahoma, 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 nonschool 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.*

Decision Making Algorithm

The decision-making algorithm on the following page may be useful as the student, the student's family, and the school considers special education through the Other Health Impairment category. The algorithm contains simple, direct questions that may lead to a more detailed discussion with key stakeholders including the student and family. The service decision-making process may also require talking with general education teachers and other school personnel. Throughout this guide, talking with and establishing a good working relationship with the student's primary care physician and other healthcare specialists is encouraged. This collaboration is particularly important in the initial step of deciding how to serve a student with a chronic health condition. Collaborating with healthcare providers is discussed in greater detail in the *Collaborating with Community Resources* section of this guide. Also, the Oklahoma State Department of Education, Special Education Services, [Policies and Procedures for Special Education in Oklahoma](#) manual provides the following guidance when the Individualized Education Program team is planning for services:

Adverse Effects on Educational Performance

Determination of adverse educational effects must reflect consideration of the effect of the child's disability on overall educational performance. It is not intended to imply that the child must be below grade level or must be failing in an academic area to be eligible for special education and related services. In addition, eligibility for and dismissal from special education and related services programs should not be based on a sole criterion of educational deficits in basic academic performance, or

achievement scores (e.g., reading, mathematics, spelling). Consideration must be given to the factors and characteristics of the child's disability, as defined in the federal regulations.

Using this guidance coupled with the algorithm will support the team's decision-making process.

CONSIDERATIONS FOR SPECIAL EDUCATION PROGRAMMING BASED ON THE SEVERITY OF HEALTH CONDITION

<i>How does the health condition affect the child's functioning?</i>	<i>Is this health condition producing an adverse affect requiring special education?</i>
Level 1, Mild: Health condition does not interfere with day-to-day functioning and learning.	No
Level 2, Mild/Moderate: Health condition does not interfere with learning but there is the possibility of unusual episodes or crises.	Possibly
Level 3, Moderate: Health condition either presents frequent crises or so limits the child's opportunity to participate that learning is interrupted.	Yes
Level 4, Severe: Health condition is so severe that special medical attention is regularly needed. The child's opportunity for activity is so limited that he/she may not be able to participate in a general classroom.	Yes

Clay, D., 2004. *Helping schoolchildren with chronic health conditions: A practical guide*. The Guilford Press. New York, NY.
 Waisman Center, University of Wisconsin-Madison, University Center for Excellence in Developmental Disabilities, 2006, *Health Conditions and the IEP Process*.
 National Center on Secondary Education and Transition, 2006, *Parent brief: What does health have to do with transition? Everything!*
 Oklahoma State Department of Education, Special Education Services, (2007) *Policies and Procedures for Special Education in Oklahoma Manual*



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 healthcare 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.

Other Health Impairment

Section VI: Community Resources

Local

County Health Departments offer a variety of services including immunizations, adolescent health clinics, environmental health, speech and language services and developmental services. Professionals in these local offices can be a resource on health conditions you may encounter teaching in a classroom with a student with other health impairments. Contact information for county health departments:

ADAIR

600 West Hickory
Stilwell, Oklahoma 74960
(918) 696-7292

ATOKA

1006 West 13th Street
Atoka, Oklahoma 74525
(580) 889-2116

ALFALFA C/O GARFIELD COUNTY

Post Office Box 3266
Enid, Oklahoma 73701

BEAVER

Post Office Box 520
Beaver, Oklahoma 73932
(580) 625-3693

BECKHAM

115 South Fourth
Sayre, Oklahoma 73662
(580) 928-5551

400 East Third
Elk City, Oklahoma 73644
(580) 225-1173

BLAINE

521 West Fourth
Watonga, Oklahoma 73772
(580) 623-7977
<http://blaine.health.ok.gov>

BRYAN

1524 West Chuckwa
Durant, Oklahoma 74702
580-924-4285
<http://bryan.health.ok.gov>

CADDO

216 West Broadway
Anadarko, Oklahoma 73005
(405) 247-2507

CANADIAN

100 South Rock Island
El Reno, Oklahoma 73036
(405) 262-0042

1023 East Vandament
Yukon, Oklahoma 73099
(405) 354-4872

<http://canadian.health.ok.gov>

CARTER

405 South Washington
Ardmore, Oklahoma 73401
(580) 223-9705
<http://carter.health.ok.gov>

308 Franklin
Healdton, Oklahoma 73438
(580) 229-1291

CHEROKEE

912 South College
Tahlequah, Oklahoma 74464
(918) 456-8826

CHOCTAW

103 South Fourth Street
Hugo, Oklahoma 74743
(580) 326-8821
<http://choctaw.health.ok.gov>

CLEVELAND

250 12th Ave. N.E.
Norman, Oklahoma 73071
(405) 321-4048

224 South Chestnut
Moore, Oklahoma 73160
(405) 794-1591
<http://cleveland.health.ok.gov>

COAL

1404 South Highway 75
Post Office Box 365
Coalgate, Oklahoma 74538
(580) 927-2367

COMANCHE

1010 South Sheridan Road
Post Office Box 87
Lawton, Oklahoma 73501
(580) 248-5890
<http://comanche.health.ok.gov>

COTTON

1501-A South 7th
Walters, Oklahoma 73752
(580) 875-6121

CRAIG

115 East Delaware
Vinita, Oklahoma 74301
(918) 256-7531

CREEK

1808 South Hickory
Sapulpa, Oklahoma 74066
(918) 224-5531

420 East Broadway
Post Office Box 848
Drumright, Oklahoma 74030
(918) 352-9581

408 West 4th
Bristow, Oklahoma 74010
(918) 367-3341

CUSTER

3030 Custer Avenue
Clinton, Oklahoma 73601
(580) 323-2100

220 North Bradley
Weatherford, Oklahoma 73096
(580) 772-6417
<http://custer.health.ok.gov>

DELAWARE

Highway 59 West
Post Office Drawer 370
Jay, Oklahoma 74346
(918) 253-4511

GARFIELD

2501 S. Mercer
Enid, Oklahoma 73701
580-233-0650
<http://garfield.health.ok.gov>

GARVIN

1809 South Chickasaw
Pauls Valley, Oklahoma 73075
(405) 238-7346

707 West Comanche
Lindsay, Oklahoma 73052
(405) 756-2928

GRADY

2116 Iowa Street
Chickasha, Oklahoma 73018
(405) 224-2022

GRANT

115 North Main
Medford, Oklahoma 73759
(580) 395-2906
<http://grant.health.ok.gov>

GREER

2100 North Louis Tittle
Mangum, Oklahoma 73554
(580) 782-5531
<http://greer.health.ok.gov>

HARMON

1104 North Seventh
Hollis, Oklahoma 73550
(580) 688-3348

HARPER

7th & Oklahoma, Suite 9
Laverne, Oklahoma 73848
(580) 921-2029

HASKELL

1407 Northeast D St.
Stigler, Oklahoma 74462
(918) 967-3304

HUGHES

200 McDougal Drive
Holdenville, Oklahoma 74848
(405) 379-3313
<http://hughes.health.ok.gov>

JACKSON

401 West Tamarack Road
Altus, Oklahoma 73521-1599
(580) 482-7308

JEFFERSON

107 East Anderson Avenue
Waurika, Oklahoma 73573
(580) 228-2313

JOHNSTON

1080 South Byrd Street
Tishomingo, Oklahoma 73460
(580) 371-2470

KAY

433 Fairview
Ponca City, Oklahoma 74601
(580) 762-1641

1706 South Main

Blackwell, Oklahoma 74631
(580) 363-5520

KINGFISHER

124 East Sheridan
Courthouse Annex Room #101
Kingfisher, Oklahoma 73750
(405) 375-3008
<http://kingfisher.health.ok.gov>

KIOWA

431 West. Elm
Hobart, Oklahoma 73651
(580) 726-3316

LATIMER

201 West Main
Wilburton, Oklahoma 74578
(918) 465-5673

LeFLORE

1212 Reynolds
P.O. Box 37
Poteau, Oklahoma 74953
(918) 647-8601

205 Dallas Street
Post Office Box 964
Talihina, Oklahoma 74571
(918) 567-2141

LINCOLN

101 Meadow Lane
Chandler, Oklahoma 74834
(405) 258-2640
<http://lincoln.health.ok.gov>

LOGAN

215 Fairgrounds Road, Suite A
Guthrie, Oklahoma 73044
(405) 282-3485
<http://logan.health.ok.gov>

LOVE

200 C.E. Colston Drive
Marietta, Oklahoma 73448
(580) 276-2531

McCLAIN

919 North Ninth Street
Purcell, Oklahoma 73080
(405) 527-6541

107 South Main
Post Office Box 130
Blanchard, Oklahoma 73010
(405) 485-3319

McCURTAIN

1400 Lynn Lane
Idabel, Oklahoma 74745
(580) 286-6628
<http://pushmataha.health.ok.gov>

McINTOSH

29 Hospital Road
Post Office Box 71
Eufaula, Oklahoma 74432
(918) 689-7774

MAJOR

501 East Broadway
Fairview, Oklahoma 73737
(580) 227-3362
<http://major.health.ok.gov>

MARSHALL

310 West Lillie Boulevard
 Post Office Box 476
 Madill, Oklahoma 73446
 (580) 795-3705
<http://marshall.health.ok.gov>

MAYES

111 Northeast First
 Pryor, Oklahoma 74361
 (918) 825-4224

MURRAY

730 Cambridge Drive
 Sulphur, Oklahoma 73086
 (580) 622-3716

MUSKOGEE

530 South 34th Street
 Muskogee, Oklahoma 74401
 (918) 683-0321
<http://muskogee.health.ok.gov>

NOBLE

300 East Fir Street
 Perry, Oklahoma 73077-4902
 (580) 336-2257

OKFUSKEE

125 North Second
 Okemah, Oklahoma 74859
 (918) 623-1800
<http://okfuskee.health.ok.gov>

OKLAHOMA CITY-COUNTY

921 Northeast 23rd Street
 Oklahoma City, Oklahoma
 73105
 (405) 427-8651
<http://www.cchdoc.com/>

OKMULGEE

1304 R.D. Miller Drive
 Okmulgee, Oklahoma 74447
 (918) 756-1883

404 East Broadway
 Henryetta, Oklahoma 74437
 (918) 652-8250

102 West Main Street
 Post Office Box 989
 Beggs, Oklahoma 74421
 (918) 267-3606

OSAGE

535 Leahy, Suite 103
 Pawhuska, Oklahoma 74056
 (918) 287-3740

OTTAWA

1930 North Elm
 Miami, Oklahoma 74354
 (918) 540-2481

PAWNEE

639 Seventh Street
 Pawnee, Oklahoma 74058
 (918) 762-3643

1390 West Cherokee
 Cleveland, Oklahoma 74020
 (918) 358-2546

PAYNE

1321 West 7th Avenue
 Stillwater, Oklahoma 74074
 (405) 372-8200

1001 East Cherry Street
 Post Office Box 168
 Cushing, Oklahoma 74023
 (918) 225-3377

PITTSBURG

1400 East College Avenue
 McAlester, Oklahoma 74501
 (918) 423-1267

PONTOTOC

1630 East Beverly
 Suite 101
 Ada, Oklahoma 74820
 (580) 332-2011

POTTAWATOMIE

1904 Gordon Cooper Drive
 Shawnee, Oklahoma 74801
 (405) 273-2157

PUSHMATAHA

318 West Main
 Antlers, Oklahoma 74523
 (580) 298-6624
<http://pushmataha.health.ok.gov>

Post Office Box 118
 Highway 2 & Cherokee Street
 Clayton, Oklahoma 74536
 (918) 569-7973

ROGERS

2664 North Highway 88, Unit A
 Claremore, Oklahoma 74017
 (918) 341-3166
<http://rogers.health.ok.gov>

SEMINOLE

200 South Brown
 Wewoka, Oklahoma 74884
 (405) 257-5401

1900 Boren Blvd.
 Seminole, Oklahoma 74868
 (405) 382-4369
<http://seminole.health.ok.gov>

SEQUOYAH

612 North Oak Street
 Sallisaw, Oklahoma 74955
 (918) 775-6201
<http://sequoyah.health.ok.gov>

STEPHENS

1401 Bois D'Arc
 Duncan, Oklahoma 73533
 (580) 252-0270

TEXAS

1410 North East Street
 Guymon, Oklahoma 73942
 (580) 338-8544

TILLMAN

1500 North Main Street
 Frederick, Oklahoma 73542
 (580) 335-2163

TULSA CITY-COUNTY

5051 S. 129th East Avenue
 Tulsa, Oklahoma 74134
 (918) 582-9355
<http://www.tulsa-health.org/>

WAGONER

212 North Pierce
 Wagoner, Oklahoma 74467
 (918) 485-3022

Post Office Box 962
 28596 E. 141st Street., South
 Coweta, Oklahoma 74429
 (918) 486-2845

WASHINGTON

5121 S.E. Jacquelyn Lane
 Bartlesville, Oklahoma 74006
 (918) 335-3005

WOODS

901 - 14th Street
 Alva, Oklahoma 73717
 (580) 327-3192
<http://woods.health.ok.gov>

WOODWARD

1631 Texas Avenue
 Woodward, Oklahoma 73801
 (580) 256-6416

County Departments of Human Services provide a wide array of services including medical, developmental, nutritional and safety. Professionals from the Oklahoma Department of Human Services can provide information and access to other community based resources. Contact information for local offices are:

ADAIR

Section Line Rd.
Rt. 1, Box 42
Stilwell, Oklahoma 74960
(918) 696-7736

ALFALFA

101 South Grand Street
Cherokee, Oklahoma 73728
(580) 596-3335

ATOKA

401 North Greathouse Drive
Atoka, Oklahoma 74525
(580) 889-3394

BEAVER

111 West 2nd Street.
Beaver, Oklahoma 73932
(580) 625-3441

BECKHAM

312 East Madden
Sayre, Oklahoma 73662
(580) 928-4000

BLAINE

410 West. Main St.
Watonga, Oklahoma 73772
(580) 623-2000

BRYAN

4302 Hwy. 70 West
Durant, Oklahoma 74702
(580) 931-2500

CADDO

201 Hardee's
Anadarko, Oklahoma 73005
(405) 247-4000

CANADIAN

7901 East. US Highway 66
El Reno, Oklahoma 73036
(405) 295-2000

CARTER

925 West Broadway
Ardmore, Oklahoma 73401
(580) 490-3600

CHEROKEE

1298 West Fourth Street
Tahlequah, Oklahoma 74465
(918) 207-4500

CHOCTAW

1602 East Kirk
Hugo, Oklahoma 74743
(580) 317-2900

CIMARRON

One Courthouse Square
Boise City, Oklahoma 73933
(580) 544-2512

CLEVELAND

631 East Robinson
Norman, Oklahoma 73071
(405) 573-8300

COAL

One North Main Street
Coalgate, Oklahoma 74538
(580) 927-2379

COMANCHE

2609 Southwest. Lee Blvd.
Lawton, Oklahoma 73505
(580) 250-3600

COTTON

1501 South 7th Street
Walters, Oklahoma 73572
(580) 875-4000

CRAIG

310 North Wilson
Vinita, Oklahoma 74301
(918) 713-5000

CREEK

17 South Elm
Sapulpa, Oklahoma 74066
(918) 746-3300

CUSTER

190 South 31st
Clinton, Oklahoma 73601
(580) 331-1900

DELAWARE

438 South 9th St.
Jay, Oklahoma 74346
(918) 253-4213

DEWEY

Broadway and Ruble Street
Taloga, Oklahoma 73667
(580) 328-5546

ELLIS

103 North Washington
Arnett, Oklahoma 73832
(580) 885-7546

GARFIELD

2405 Mercer Dr.
Enid, Oklahoma 73702
(580) 548-2100

GARVIN

2304 South Chickasaw
Pauls Valley, Oklahoma 73075
(405) 238-6461

GRADY

1707 West Frisco Ave.
Chickasha, Oklahoma 73018
(405) 574-7400

GRANT

112 East Guthrie
Medford, Oklahoma 73759
(580) 395-3312

GREER

130 North Oklahoma
Mangum, Oklahoma 73554
(580) 782-3311

HARMON

114 West Hollis
Hollis, Oklahoma 73550
(580) 688-3361

HARPER

1001 North Hoy
Buffalo, Oklahoma 73834
(580) 735-2541

HASKELL

#9 Highway East
Stigler, Oklahoma 74462
(918) 967-4658

HUGHES

801 Kingsberry Road
Holdenville, Oklahoma 74848
(405) 379-7231

JACKSON

201 South. Main St.
Altus, Oklahoma 73521
(580) 480-3400

JEFFERSON

400 East Hwy 70
Waurika, Oklahoma 73573
(580) 228-3581

JOHNSTON

1003 East Main, Ste. 4
Tishomingo, Oklahoma 73460
(580) 371-4000

KAY

801 West Grand Avenue.
Ponca City, Oklahoma 74601
(580) 765-2656

KINGFISHER

102 West Coronado
Kingfisher, Oklahoma 73750
(405) 375-3867

KIOWA

430 South Main
Hobart, Oklahoma 73651
(580) 726-6500

LATIMER

1809 Highway 270 East
Wilburton, Oklahoma 74578
(918) 465-5800

LEFLORE

511 South Harper
Poteau, Oklahoma 74953
(918) 649-2300

LINCOLN

2020 East First Street
Chandler, Oklahoma 74834
(405) 258-6800

LOGAN

1414 South Division
Guthrie, Oklahoma 73044-4946
(405) 264-2700

LOVE

311 South Highway 77, Ste. A
Marietta, Oklahoma 73448
(580) 276-3383

MAJOR

1425 North Main
Fairview, Oklahoma 73737
(580) 227-3759

MARSHALL

111 Highway 70 West
Madill, Oklahoma 73446-1024
(580) 795-8100

MAYES

501 South Elliott
Pryor, Oklahoma 74361
(918) 824-4900

MCCLAIN

1930 South Green Ave.
Purcell, Oklahoma 73080
(405) 527-6511

MCCURTAIN

1300 Southeast Adams
Idabel, Oklahoma 74745
(580) 208-3400

MCINTOSH

Hospital Road, & Hwy. 69
Eufaula, Oklahoma 74432
(918) 689-1200

MURRAY

1019 West Wyandotte
Sulphur, Oklahoma 73086-4421
(580) 622-2186

MUSKOGEE

727 South 32nd
Muskogee, Oklahoma 74403
(918) 684-5300

NOBLE

205 15th Stree
Perry, Oklahoma 73077
(580) 336-5581

NOWATA

309 Delaware
Nowata, Oklahoma 74048
(918) 273-2327

OKFUSKEE

119 South First St.
Okemah, Oklahoma 74859
(918) 623-1363

OKLAHOMA-SOUTHWEST

401 West Commerce
Oklahoma City, Oklahoma
73109
(405) 644-5700

OKLAHOMA-MIDWEST CITY

9901 Southeast. 29th Street
Midwest City, Oklahoma 73130
(405) 739-8000

OKLAHOMA-KELLY

2409 North Kelley Avenue
Oklahoma City, Oklahoma
73111
(405) 522-5818

OKLAHOMA-MAYFAIR

2821 Northwest 50th Street
Oklahoma City, Oklahoma
73112
(405) 602-5700

OKLAHOMA-ROCKWELL

7201 Northwest. 10th Street
Bethany, Oklahoma 73127
(405) 470-6200

OKLAHOMA-CROSSROADS

1115 Southeast 66th Street
Oklahoma City, Oklahoma
73149
(405) 604-8800

OKMULGEE

5005 North Wood Dr.
Okmulgee, Oklahoma 74447
(918) 752-2000

OSAGE

550 Kihekah
Pawhuska, Oklahoma 74056
(918) 287-5800

OTTAWA

2114 Denver Harnar Drive
Miami, Oklahoma 74354
(918) 541-2400

PAWNEE

501 Fifth Street
Pawnee, Oklahoma 74058
(918) 762-3606

PAYNE

711 East Krayler
Stillwater, Oklahoma 74075
(405) 707-3700

PITTSBURG

1900 South Main
McAlester, Oklahoma 74501
(918) 421-6100

PONTOTOC

1628 East Beverly, Ste 104
Ada, Oklahoma 74820
(580) 310-7050

POTTAWATOMIE

1400 North Kennedy
Shawnee, Oklahoma 74801
(405) 878-4000

PUSHMATAHA

P.O. Box 40
104 SE "B" St.
Antlers, OK 74523
(580) 298-3361

ROGER MILLS

480 East Broadway
Cheyenne, Oklahoma 73628
(580) 497-3393

ROGERS

2020 Holly Road
Claremore, Oklahoma 74018
(918) 283-8300

SEMINOLE

206 E. Second Street
Wewoka, Oklahoma 74884
(405) 257-7400

SEQUAYAH

1611 South Kerr Blvd
Sallisaw, Oklahoma 74955
(918) 776-8000

STEPHENS

1805 W. Plato Rd.
Duncan, Oklahoma 73534
(580) 251-8300

TEXAS

1000 Northeast Fourth Street
Guymon, Oklahoma 73942
(580) 338-8592

TILLMAN

125 North Ninth
Frederick, Oklahoma 73542
(580) 335-6800

TULSA-MCLAIN

3666 North Peoria
Tulsa, Oklahoma 74106
(918) 430-2300

TULSA-DOWNTOWN

444 South Houston
Tulsa, Oklahoma 74127
(918) 581-2033

TULSA-BROKEN ARROW

5051 South 129th E. A
Tulsa, Oklahoma 74134
918) 294-2000

TULSA-SKYLINE

6128 East 38th Street, Ste. 200
Tulsa, Oklahoma 74135
(918) 280-3100

WAGONER

102 Northeast. Seventh Street
Wagoner, Oklahoma 74467
(918) 614-5000

WASHINGTON

5205 Jacqueline Ln.
Bartlesville, Oklahoma 74006
(918) 338-5700

WASHITA

106 Lowber Lane
Cordell, Oklahoma 73632
(580) 832-3391

WOODS

509 Barnes
Alva, Oklahoma 73717
(580) 430-3100

WOODWARD

2119 West Main
Woodward, Oklahoma 73801
(580) 254-6000

Local offices of the Department of Rehabilitation Services offer an array of supports to individuals to assist with accessing postsecondary education and vocational services. Contact information for local offices are:

Vocational Rehabilitation

Social Services Center
1628 East Beverly, Suite 109
Ada, Oklahoma 74820-2654
Office: 580 332-2785
Fax: 580 436-3542

Visual Services

1628 East Beverly, Suite 110
Ada, Oklahoma 74820-2654
Office: 580 436-2430
Fax: 580 436-9049

Vocational Rehabilitation

1001 East. 14th Street
Ada, Oklahoma 74820
Office: 580 332-0178
Fax: 580 332-4712

Vocational Rehabilitation

1121 North Spurgeon,
Suite. B
Altus, Oklahoma 73521
Office: 580 482-8605
Fax: 580 477-2240

Vocational Rehabilitation

1040 8th Street
Alva, Oklahoma 73717
Office: 580 327-1214
Fax: 580 327-8643

Vocational Rehabilitation

333 West Main, Suite 430
Ardmore, Oklahoma 73401
Office: 580 226-1808
Fax: 580 223-4265

Vocational Rehabilitation

4100 South East Adams Road,
Suite E104
Bartlesville, Oklahoma 74006
Office: 918 333-0760
Fax: 918 331-9012

Visual Services

1000 Choctaw, Suite 2
Chickasha, Oklahoma 73018
Office: 405 574-1701
Fax: 405 222-5728

Vocational Rehabilitation

1000 Choctaw, Suite 2
Chickasha, Oklahoma 73018
Office: 405 574-1700
Fax: 405 222-5728

Vocational Rehabilitation

24797 South Hwy 66, Unit 5
Claremore, Oklahoma 74019
Office: 918 341-8122
Fax: 918 342-0355

Vocational Rehabilitation

1105 West Main, Suite A3
Duncan, Oklahoma 73533
Office: 580 255-1115
Fax: 580 255-3740

Vocational Rehabilitation

801 West Main, Ste. A
Durant, Oklahoma
74701 Office: 580 924-2677
Fax: 580 924-0208

Vocational Rehabilitation 225

West Maple
Enid, Oklahoma 73701-4011
Office: 580 233-0244
Fax: 580 233-6535

Visual Services

225 West Maple
Enid, Oklahoma 73701-4011
Office: 580 233-6514
Fax: 580 233-6535

Vocational Rehabilitation

508 North Roosevelt
Guymon, Oklahoma
73942 Office: 580 338-2043
Fax: 580 338-1169

Vocational Rehabilitation

513 East Washington
Idabel, Oklahoma 74745-3325
Office: 580 286-3389
Fax: 580 286-7466

Visual Services

513 East Washington
Idabel, Oklahoma 74745-3325
Office: 580 286-3789
Fax: 580 286-7466

Vocational Rehabilitation

Lawton Evaluation Center
1324 Northwest 53rd Street
Lawton, Oklahoma 73505-4648
Office: 580 585-4220
Fax: 580 585-4234

Vocational Rehabilitation

1332 Northwest 53rd Street
Lawton, Oklahoma 73505-4648
Office: 580 585-4200
Fax: 580 585-4232

Visual Services

1332 Northwest 53rd Street
Lawton, Oklahoma 73505-4648
Office: 580 585-4250
Fax: 580 585-4232

Visual Services

321 South Third, Suite 2B
McAlester, Oklahoma 74501
Office: 918 302-4250
Fax: 918 302-4220

Vocational Rehabilitation

321 South Third, Suite 2
McAlester, Oklahoma 74501
Office: 918 302-4200
Fax: 918 302-4220

Vocational Rehabilitation

200 I Northeast
Miami, Oklahoma 74354-6434
Office: 918 542-4716
Fax: 918 540-0072

Vocational Rehabilitation

1104 South Air Depot Blvd., Suite. 10
Midwest City, Oklahoma 73110
Office: 405 737-4897
Fax: 405 737-6907

Visual Services

733 South 32nd Street
Muskogee, Oklahoma 74401
Office: 918 781-4162
Fax: 918 781-4177

Vocational Rehabilitation

733 South 32nd Street
Muskogee, Oklahoma 74403
Office: 918 781-4150
Fax: 918 781-4177

Vocational Rehabilitation

2227 West Lindsey, Suite 1200
Norman, Oklahoma 73069
Office: 405 447-0295
Fax: 405 447-5326

Vocational Rehabilitation

2401 Northwest 23rd Street, Suite 21
Oklahoma City, Oklahoma 73107
Office: 405 522-2506
Fax: 405 522-2554

Vocational Rehabilitation

5813 South Robinson
Oklahoma City, Oklahoma 73109
Office: 405 635-2750
Fax: 405 631-8115

Visual Services

2401 Northwest 23rd Street,
Suite 91
Oklahoma City, Oklahoma 73107
Office: 405 522-3333
Fax: 405 522-3332

Vocational Rehabilitation

2401 Northwest 23rd Street,
Suite 59
Oklahoma City, Oklahoma 73107
Office: 405 522-6525
Fax: 405 522-6545

Vocational Rehabilitation

Services to the Deaf and Hard of
Hearing
2401 Northwest 23rd Street,
Suite 65
Oklahoma City, Oklahoma 73107
Office: 405 522-7930
Fax: 405 522-7948

Vocational Rehabilitation

5813 South Robinson
Oklahoma City, Oklahoma 73109
Office: 405 635-2774
Fax: 405 616-9990

Vocational Rehabilitation

2401 Northwest 23rd Street,
Suite 51
Oklahoma City, Oklahoma 73107
Office: 405 522-7945
Fax: 405 522-7948

Vocational Rehabilitation

Employment Support Services
2401 Northwest 23rd Street,
Suite 47
Oklahoma City, Oklahoma 73107
Office: 405 522-6530
Fax: 405 522-7980

Visual Services

Dean A. McGee Eye Institute
608 Stanton L. Young Blvd.
Oklahoma City, Oklahoma 73104
Office: 405 271-6632
Fax: 405 272-0642

Vocational Rehabilitation

2401 Northwest 23rd Street, Suite 47
Oklahoma City, Oklahoma 73107
Office: 405 522-7959

Visual Services

Business Enterprise Program
8 Northwest. 8th Street
Oklahoma City, Oklahoma 73102
Office: 405 231-1060
Fax: 405 231-1070

Visual Services

Oklahoma Library for the Blind
and Physically Handicapped
300 Northeast 18th Street
Oklahoma City, Oklahoma 73105
Office: 405 521-3514
Fax: 405 521-4582

Vocational Rehabilitation

1801 East 4th
Okmulgee, Oklahoma 74447
Office: 918 756-6435
Fax: 918 756-7532

Vocational Rehabilitation

Carl Albert State College
1507 South McKenna, Suite 106A
Poteau, Oklahoma 74953-5207
Office: 918 647-8121
Fax: 918 647-8929

Vocational Rehabilitation

217 West 5th, Suite 2A
Stillwater, Oklahoma 74076-1053
Office: 405 372-1995
Fax: 405 377-2036

Visual Services

217 West 5th, Suite 1
Stillwater, Oklahoma 74074-4056
Office: 405 372-2017
Fax: 405 372-8654

Vocational Rehabilitation

214 South Muskogee
Tahlequah, Oklahoma 74464
Office: 918 456-6193
Fax: 918 456-8396

Visual Services

116 North Greenwood
Tulsa, Oklahoma 74120-1409
Office: 918 587-3453
Fax: 918 584-2538

Vocational Rehabilitation

125 North Greenwood, Suite 300
Tulsa, Oklahoma 74120-1444
Office: 918 382-7700
Fax: 918-583-5414

Vocational Rehabilitation

8740 East 11th Street, Suite F
Tulsa, Oklahoma 74112-7957
Office: 918 836-5556
Fax: 918 835-2358

Visual Services [VS#64]

444 South Houston, Suite 200
Tulsa, Oklahoma 74127-8990
Office: 918 581-2301
Fax: 918 581-2624

Vocational Rehabilitation

444 South Houston, Suite 200
Tulsa, Oklahoma 74127-8990
Office: 918 581-2301
Fax: 918 583-9210

Vocational Rehabilitation

101 North Greenwood
Tulsa, Oklahoma 74120-1444
Office: 918 587-3226
Fax: 918 587-3440

Visual Services

441 North Wilson
Vinita, Oklahoma 74301-2432
Office: 918 256-5275
Fax: 918 256-5846

Vocational Rehabilitation

441 North Wilson
Vinita, Oklahoma 74301-2432
Office: 918 256-5509
Fax: 918 256-5846

Visual Services

1501 Lera Drive, Suite #1
Weatherford, Oklahoma 73096
Office: 580 816-4100
Fax: 580 816-4128

Vocational Rehabilitation

1501 Lera Drive, Suite #1
Weatherford, Oklahoma 73096
Office: 580 816-4100
Fax: 580 816-4128

Visual Services

1611 Main, Suite 204
Woodward, Oklahoma 73801
Office: 580 256-2565
Fax: 580 256-2285

Vocational Rehabilitation

2411 Williams Ave., Suite. 111
Woodward, Oklahoma 73801
Office: 580 256-6738
Fax: 580 256-2285

State

Oklahoma State Department of Education

Oliver Hodge Education Office Building
2500 North. Lincoln Boulevard
Oklahoma City, Oklahoma 73105
(405) 521-3301
<www.sde.state.ok.us>

Oklahoma State Department of Human Services

Sequoyah Memorial Office Building,
2400 North Lincoln Boulevard
Oklahoma City, Oklahoma 73105
(405) 521-3646
<www.okdhs.org>

Oklahoma State Department of Health

1000 Northeast 10th Street
Oklahoma City, Oklahoma 73117
405/271-5600
<<http://www.ok.gov/health/>>

Oklahoma Department of Rehabilitation Services

3535 Northwest 58th Street, Suite 500
Oklahoma City, Oklahoma 73112-4815
(405) 951-3400
<www.okrehab.org>

Oklahoma Department of Mental Health and Substance Abuse Services

1200 Northeast 13th Street
Oklahoma City, Oklahoma 73152
(405) 522-3908
<www.odmhsas.org>

National

Healthy and Ready to Work National Center

<www.hrtw.org>

American Diabetes Association

<www.childrenwithdiabetes.com>
<www.diabetes.org>

Arthritis Foundation

<www.arthritis.org>

American Cancer Society

<www.cancer.org>

American Heart Association

<www.americanheart.org>

ADHD Links

<<http://user.cybrzn.com/~kenyonck/add/Links>>

Angelman Syndrome Information for Families and Professionals

<<http://www.asclepius.com/angel/>>

American Sickle Cell Anemia Association

<<http://www.ascaa.org>>

ASPEN Inc.-Asperger Syndrome

<www.aspennj.org>

Association of Youth with Chronic Fatigue

<<http://www.ayme.org.uk/>>

Chronic Fatigue Association of America

<<http://www.cfids.rg/>>

Chronic Fatigue Immune Dysfunction Syndrome

<<http://www.cfidsinsights.com/>>

Combined Health Information Database

<<http://chid.nih.gov/>>

Cystic Fibrosis Foundation

<www.cff.org>

Dermatitis Information

<<http://www.derm-infonet.com/>>

Epilepsy Foundation

<www.epilepsyfoundation.org>

Hemophilia Home Page

<www.hemophilia.org>

IDEA Partnership

<www.ideapractices.org>

Klinefelter Syndrome

<<http://www.genetic.org/ks/>>

Leukemia Lymphoma Society

<www.leukemia-lymphoma.org>

National Library of Medicine

<www.nlm.nih.gov>

Multiple Chemical Sensitivity

<www.multiplechemicalsensitivity.org>

National Brain Tumor Foundation

<www.brainumor.org>

National Cancer Institute

<<http://cis.nci.nih.gov>>

National Organization for Rare Disorders, Inc. (NORD)

<<http://www.rarediseases.org/>>

Tourette Syndrome Association

<ts@tsa-usa.org>



Other Health Impairment

Section VII: 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 2005-2006 National Survey of Children with Special Health Care Needs, almost 20% of Oklahoma families with children and youth with chronic healthcare conditions were at or below the federal poverty level (\$18,310 for a family of three). Another 17% of Oklahoma families with children and youth with chronic health care conditions were at or below 200% of the federal poverty level (\$36,620 for a family of three). 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.

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.

Effective Helping

Over the last fifteen years Drs. Carl Dunst and Carol Trivette have studied how best to help families with children in various service programs. Their work has led to an approach that focuses on the whole family, supports existing strengths, and fosters family members acquiring additional competencies. As early as 1988 they defined effective helping as "supporting people as they become better able to solve their own problems, meet their own needs, make their own decision, and reach their own dreams by promoting the competencies that support and strengthen functioning in a way that permits a greater sense of individual control over their own developmental course." The chart below includes descriptors of effective helping in three categories.

Pre-helping attitudes include how to approach families, helping behaviors are how professionals interact with families, and post-helping responses involve management of the professional/family relationship over time.

PRE-HELPING ATTITUDES	HELPING BEHAVIORS	POST-HELPING RESPONSES
<ul style="list-style-type: none"> • Sees the family as having positive attributes • Emphasizes the family's responsibility for meeting needs and solving problems • Holds high expectations regarding the capacity of the family's competence • Emphasizes building on family's strengths • Takes a proactive stance toward helping relationship • Focuses on promoting the family 	<ul style="list-style-type: none"> • Employs active and reflective listening skills • Helps family clarify concerns and needs • Offers help in response to family's needs • Offers help that is normative • Offers help that is congruent with and matches family's appraisal of needs • Promotes acquiring skills to meet needs, solve problems and achieve aspirations • Employs partnerships in solving problems 	<ul style="list-style-type: none"> • Accepts and respects family's decisions • Minimizes the sense of indebtedness • Permits reciprocal professional exchanges • Minimizes the costs of acceptance • Enhances a sense of efficacy regarding involvement in needs • Maintains contact all times; shares only with permission
	<ul style="list-style-type: none"> • Allow locus of decision-making to rest with the family 	

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 the 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. 2005/2006 National Survey of children with special health Care Needs, Data Resource Center for Child and Adolescent health website. Retrieved [06/09/09] from <www.cshcndata.org>

Computations for the 2009 Annual Update of the HHS Poverty Guidelines for the 48 Contiguous States and the District of Columbia, 2009 Poverty Guideline Computations. US Department of Health & Human services website. Retrieved [06/10/09] from <http://aspe.hhs.gov/poverty/09computations.shtml>

Dunst, C., Trivette, C., Deal, A., (1994). Supporting & Strengthening Families, Brookline Books, Inc. Cambridge, MA.

Lukemeyer, A., Meyers, M. K., & Smeeding, T. (2000). Expensive children in poor families: Out-of-pocket expenditures for the care of disabled and chronically ill children in welfare families. Journal of Marriage and the Family, 62, 399–415.



Other Health Impairment

Section VIII: 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

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: _____

BIRTHDATE: _____ BIRTHDATE: _____
FIRST MIDDLE LAST MONTH/DAY/YEAR GRADE AGE DATE: _____

PARENT(S): _____

PHONE: (WORK) _____ (HOME) _____ (OTHER) _____

HOME ADDRESS: _____ DISTRICT/AGENCY: _____
STREET ADDRESS/P.O. 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*