Meeting the Needs of Students with Physical Impairments:

A Resource Manual For Minnesota Educators

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Note: Portions of this manual are excerpted from documents or other manuals published by the Minnesota Department of Education (permission granted):


Part I

Introduction:
Physically Impaired Services in the School Setting
PHYSICALLY IMPAIRED SERVICES IN THE EDUCATIONAL SETTING

Introduction
The special education category, ‘Physically Impaired’ (PI) is considered a low incidence disability area. Children and youth with physical impairments typically comprise 1.5% of the total population of students with disabilities who receive special education services. A physical impairment may be present from birth or acquired later, and may be progressive or non-progressive. There are a wide range of conditions that may result in a physical impairment. With improvements in medical technology and early diagnosis, survivability rates continue to increase and are resulting in earlier identification in the educational setting.

Historical Overview of PI Manual
The first manual designed for Minnesota educators serving students with physical impairments was titled, ‘Meeting the Needs of Students with Physical Impairments: A Resource Manual’. This manual was written in 2002 and published by the Division of Special Education, Minnesota Department of Children, Families and Learning (later changed to the Minnesota Department of Education). This manual has been used by Physical/Health Disabilities teachers throughout the state of Minnesota for the past eight years. This current revision was completed in 2011.

Defining Physical Impairment
A physical disability is a medically diagnosed chronic physical impairment, either congenital or acquired, that may adversely affect physical or academic functioning and result in the need for special education and related services (MN Rule 3525.1337, subp 1). There is a broad continuum of physical impairment and resulting implications for students. Some students may have a relatively mild disability with minimal effect on their access to and participation in school activities and related educational outcomes, while others may have a more severe disability and experience significant challenges. Each student is unique, and any particular condition may vary in severity.

Medical conditions commonly identified as physical impairments include cerebral palsy, spina bifida, spinal cord injury, muscular dystrophy, osteogenesis imperfecta, and arthrogryposis, to name a few. A physical impairment can affect development and learning in one or more of the following areas:

- Muscle tone, muscle strength, posture
- Fine and/or gross motor skills; mobility
- Communication skills
- Processing, memory, perception and attention skills
- Executive function (organization, planning, initiation of tasks, etc.)
- Psycho-social skills
A physical impairment may often result in the need for specialized equipment, technology and/or individualized curriculum and instruction to address the above needs.

**Student Characteristics**
Most students who meet the criteria for Physically Impaired (PI) have difficulty with completion of classroom tasks involving motor skills within the same timelines as peers, including but not limited to:

- Navigating the school environment (hallway transitions, emergency evacuations)
- Accessing the classroom environment and materials
- Completing activities of daily living (eating, dressing, restroom)
- Participating in physical education and recess activities
- Completing classroom tasks that require a motor response

Many students have accompanying neurological impairments which may impact organizational and independent work skills. It is not unusual for students who have physical impairments to demonstrate academic needs that result in atypical learning profiles. For example, a physical impairment can affect a student’s learning style and the way he/she is able to:

- Solve problems
- Process information
- Coordinate movement
- Participate in the classroom
- Learn new skills and/or demonstrate knowledge
- View and/or advocate for oneself

Although many students with physical impairments will follow the same curriculum as their peers, some variations may include:

- Adapting the content to enable participation in some subject areas
- Alternative methods for demonstrating knowledge or skills
- Additional staff support
- Additional or supplemental instruction, i.e. mobility skills, keyboarding, specialized communication methods, and use of assistive technology
- The rate at which a student moves through the curriculum

A student may have reduced stamina and become easily fatigued. Some students may have a history of and/or require frequent hospitalization. Some students may also have additional impairments such as an intellectual impairment, learning difficulties, or a sensory impairment. Some students with physical impairments may also be gifted.
Common Educational Needs and Adaptations
The most common components of an educational program for a student who has a physical impairment are adaptations to accommodate the student’s educational needs. They may include:

- Instructional strategies for organization, attention, memory, and atypical learning styles
- Preferential seating and locker assignment
- Time extensions for assignment completion
- Assignment and/or test modifications (reduced writing requirements, alternate means of demonstrating knowledge)
- Assistive technology and adaptive equipment to compensate for motor and perceptual skill deficits
- Additional set of textbooks for home
- Provision of teacher or peer notes
- Additional time for transitions
- Alterations in school schedule to accommodate physical and medical needs (restroom, use of specialized equipment, personal care, visits with related service providers)

It is important that students identified with physical limitations be provided with access to the same educational experiences and opportunities for success as their peers. Other important considerations for students with physical impairments include emergency evacuation planning for the building and school bus, and development of an individualized health plan (IHP) if there are accompanying chronic health needs. The IEP team should also address safety and mobility concerns in the educational environment.

Variability
There is great variability among different physical disabilities. Specific disabilities may be very mild and result in minimal educational needs; or more severe, resulting in significant educational needs. These needs may require specialized equipment, technology, instruction, and possibly paraprofessional support. While most physical disabilities are static with minimal change in basic motor skills, there are some disabilities that are degenerative (e.g., muscular dystrophy). Special planning and considerations are necessary for such situations.

Myths/Common Misconceptions
There are many myths and misconceptions about students with physical impairments. It is important to remember that having a physical disability does not automatically ensure that the student meets the criteria for Physically Impaired. Another common misconception for a student with a physical impairment is that the student also has a cognitive impairment. This is frequently assumed when the physical impairment is more severe, impacting communication and mobility. There is the same range of cognitive skills for students with a physical impairment as found with other students. An additional misconception is that physical and/or occupational therapy can cure a disability. While therapy may be able to increase a student’s range of
motion and ability to complete different gross and fine motor tasks, the student will continue to have the same medical diagnosis and physical disability.

**Eligibility Criteria**
The Minnesota State criteria for Physically Impaired require documentation of a medically diagnosed physical impairment, which is usually a motor disability, as well as documentation of educational implications related to the physical impairment. The educational implications can be related to a lack of functional level of organizational or independent work skills; or to the inability to manage or complete motoric portions of classroom tasks within time constraints. Classroom tasks include any developmentally appropriate activities across educational/school environments, including the physical education setting, the playground, restroom, lunchroom, hallways, bus, etc. A student may also qualify for services if the physical impairment interferes with educational performance as shown by an achievement deficit of 1.0 standard deviation or more on an academic achievement test. (Refer to the State criteria for specific components.) The criteria do not include a discrepancy between the student’s cognitive skills and academic performance. The criteria also require that a teacher licensed in the area of Physical/Health Disabilities (P/HD) be included as a member of the evaluation and IEP team.

**P/HD Services in the Educational Setting**
As stated in Minnesota Rules, the Physical/Health Disabilities (P/HD) teacher is a required member of the Individualized Education Program (IEP) team and participates in planning and completing evaluations for students with physical impairments from birth to age 21. The P/HD teacher may also provide direct and/or indirect services to address educational adaptations and instructional strategies unique to a student’s physical impairment. Other responsibilities include assisting the team in developing appropriate goals and objectives; accommodations and/or modifications to curriculum, materials, and instructional methods; and utilizing technology to ensure access to curriculum, materials, and the educational environment. A P/HD teacher may also provide disability-specific in-services to staff or students. Other service providers commonly include the following: building level special education staff, physical therapist (PT), occupational therapist (OT), developmental adapted physical education (DAPE) teacher, school nurse, speech/language clinician or pathologist, communication disorders specialist (CDS), school social worker, and assistive technology specialist.

**Role of the P/HD Teacher**
In clarification, students qualify under the disability category of Physically Impaired (PI), but the teacher licensure is termed, ‘Physical/Health/Disabilities’ (P/HD). The student who receives special education under the Physically Impaired category must have a licensed P/HD teacher as a member of his or her IEP team, who would then serve as part of the special education team and assist with the evaluation process, IEP planning, and provide special education services as determined appropriate by the team.
Currently, licensed P/HD teachers are able to provide services to students with a physical impairment from birth to age 21. Note: An earlier and still valid teacher license offered through Minnesota in the past is the Physically Handicapped (PH) teacher license.

It is important to note that when a student qualifies under the PI category, a P/HD teacher must be included on that student’s educational team. Although the categorical areas of OHD and TBI do not currently have specific teacher licensure, the P/HD teacher may be of assistance to teams working with students with complex, chronic health impairments or traumatic brain injuries. (Note: For more information on the role of the P/HD teacher, see part IV.

Statewide Professional Resources

Regional Low Incidence Projects
Coordination of special education activities for low incidence student populations are accomplished through planning and collaboration between the Regional Low Incidence Projects that cover all eleven Regions in Minnesota, the statewide disability Specialists and other agencies, (such as the MN Low Incidence Projects) in the areas of low incidence disabilities. For specific state and regional information, refer to the Statewide Low Incidence Resources Contact Information in the Appendices.

Minnesota Low Incidence Projects
The Minnesota Low Incidence Projects are designed to assist school districts across the state in fulfilling federal requirements in the areas of implementation of the IDEA, professional development and insuring the availability of high quality staff in the low incidence areas of special education. Funding for the MN Low Incidence Projects is made possible through a grant from the Minnesota Department of Education, and provides funding for technical resources and support offered through the statewide PI specialist position, the MN Low Incidence Projects website, the P/HD Network and List Serve, and more. Descriptions of some of these resources are included below.

Statewide Specialist for the Physically Impaired
The Statewide PI specialist provides technical assistance and training to Physical/Health Disabilities teachers and other professionals in the field who have a vested interest in meeting the educational needs of students with physical impairments. In addition, the Statewide PI specialist also coordinates statewide P/HD network meetings, assists with annual conference planning, and meets monthly with other state low incidence specialists and regional low incidence facilitators to assist in statewide planning and initiatives.

Website
The MN Low Incidence Projects website provides updated information, resources and links relevant to the field of Physical/Health Disabilities, including P/HD Network information and
meeting minutes, professional training opportunities and events, technical training materials and more. For more information, go to: [http://www.mnlowincidenceprojects.org/pi.html](http://www.mnlowincidenceprojects.org/pi.html)

**Statewide Physical/Health Disabilities Network**

*An Early History*

School services in the area of Physically Impaired first began in Minnesota in the late 1950’s, when a State Plan for Crippled Children was developed. The law included a definition that acknowledged both physically impaired and other health impaired learners. Up until 1975, services were provided in self-contained classrooms. In 1975, this law was replaced by the Federal 94-142 legislation, which mandated educational services for all children, regardless of ability. In the late 1970’s, the Minnesota POHI (Physically and Other Health Impaired) Network came into being. POHI practitioners were struggling with the proposed focus of only working with students who had severe/profound physical impairments. Typically, students with mild physical impairments who had more academic abilities were not included under this service delivery model.

During the 1980’s, the POHI Network further defined its membership, and developed a plan of action. At this time, the University of Minnesota was the only post-secondary institution in the state offering a licensure in the category of Physically Handicapped (PH). This licensure program continued to develop and grow through the early 1990’s, until a limit of 20 enrolled students per year was imposed. In 1992, the POHI Network merged with the Council for Exceptional Children’s Division of Physically Impaired, allowing it to become a representative organization for members of both groups.

*Recent History*

Throughout the 1990’s, the POHI Network continued to redefine its purpose and mission. The organizational name was changed to the Minnesota Physical/Health Disabilities Network, and reflected a committed group of professionals who served students in the PI, OHD and TBI categories of special education. The teacher licensure was officially changed to Physical/Health Disabilities (P/HD) Teacher, and allowed these teachers to serve children and youth with physical impairments from birth to age 21. Teachers were encouraged to take the necessary Early Childhood/Special Education (ECSE) coursework to obtain this revised licensure, which many did.

*Today*

Currently, approximately 130 professionals are members of the MN Physical/Health Disabilities Statewide Network, although some licensed P/HD teachers are working in other areas or capacities, such as a related special education field or administration. Network members devote time to planning both meeting and annual conference activities, and address complex issues relevant to our field, such as: professional recruitment, licensure standards, higher education.
training, role of the school nurse, guidelines for paraprofessionals, development and promotion
of the State P/HD list serve and website, ongoing supplements and revisions to our professional
manuals, and development of professional guidelines, tools, and resource materials. The
Network also works closely with the medical community with regard to staying abreast of
medical research and care/treatment implications related to physical impairments in the school
setting.

Physical/Health Disabilities List Serve
The statewide P/HD List Serve is a tool provided through the MN Low Incidence Projects grant
to P/HD Network members for the purpose of allowing P/HD teachers to electronically send
and/or share timely information, resources, or questions pertinent to the field of
Physical/Health Disabilities. For more information on subscribing to the list serve, contact the
Statewide PI specialist, or visit the PI Resources webpage on the MN Low Incidence Projects
website.

Statewide P/HD Professional Coaching Program
In an effort to strengthen Minnesota’s support for educators teaching in several low incidence
disability areas such as Physical/Health Disabilities, a statewide mentoring/professional coaching
program for new special educators in low incidence fields was initiated in 2004. Research
suggests that participation in well-designed and well-implemented professional coaching
programs can provide educators with the kinds of information, support, and connection to
professional communities that may strengthen the start or continuation of their careers. Many
schools and districts throughout the state currently offer successful professional coaching
programs, but often do not fully meet the unique needs of itinerant special educators serving
low incidence populations of students. P/HD Professional Coaching resources are now offered
in an electronic format, and accessible through the MN Low Incidence Projects website.
Part II

Minnesota State Criteria:
Physically Impaired


MINNESOTA STATE CRITERIA: PHYSICALLY IMPAIRED

3525.1337 PHYSICALLY IMPAIRED.

Subpart 1. Definition. "Physically impaired" means a medically diagnosed chronic, physical impairment, either congenital or acquired, that may adversely affect physical or academic functioning and result in the need for special education and related services.

Subpart 2. Criteria. A pupil is eligible and in need of special education instruction and services if the pupil meets the criterion in item A and one of the criteria in item B.

A. There must be documentation of a medically diagnosed physical impairment.

B. The pupil's:

(1) need for special education instruction and service is supported by a lack of functional level in organizational or independent work skills as verified by a minimum of two or more documented, systematic observations in daily routine settings, one of which is completed by a physical and health disabilities teacher;

(2) need for special education instruction and service is supported by an inability to manage or complete motoric portions of classroom tasks within time constraints as verified by a minimum of two or more documented systematic observations in daily routine settings, one of which is completed by a physical and health disabilities teacher; OR

(3) physical impairment interferes with educational performance as shown by an achievement deficit of 1.0 standard deviation or more below the mean on an individually administered nationally normed standardized evaluation of the pupil’s academic achievement.

STAT AUTH: MS s 14.389; 120.17; L 1999 c 123 s 19.20
HIST: 16 SR 1543; L 1998 c 397 art 11 s 3; 24 SR 1799; 26 SR 657
(Current as of 2011)
**MN Criteria Guidelines: Physically Impaired**

**3525.1337 PHYSICALLY IMPAIRED.**

**Subpart 1. Definition.** "Physically impaired" means a medically diagnosed chronic, physical impairment, either congenital or acquired, that may adversely affect physical or academic function and result in the need for special education and related services.

**Subp. 2. Criteria.** A pupil is eligible and in need of special education instruction and services if the pupil meets the criterion in item A and one of the criteria in item B.

**A. Medical Diagnosis**

*There must be documentation of a medically diagnosed physical impairment.*

The Minnesota State criteria require that the physical impairment be diagnosed and documented by a licensed medical physician; a written or electronic signature is acceptable. Reports with reference to a physical impairment from hospitals or clinics, written by professional or medical staff other than a medical physician (such as a physical therapist, occupational therapist, or physician’s assistant) would not meet Minnesota State criteria for a medically diagnosed physical impairment. In addition, this must be a specific medical diagnosis. Vague language such as ‘possible’, ‘probable’, or a listing of characteristics such as low muscle tone or global motor deficits would not meet criteria for a medical diagnosis of a physical impairment as defined by criteria. The medical diagnosis of the physical impairment needs to be documented as part of the educational evaluation for qualification under the special education category of Physically Impaired. However, there are no restrictions as to the date of the documentation. Additional or repeated documentation of the physical impairment by a licensed physician is not required during 3-year re-evaluations unless there have been significant changes in the student’s medical status. However, a summary of existing and/or updated medical information should be included in every re-evaluation. Additional information on various medical diagnoses can be found in other sections of this manual, including the Disability Fact Sheets, ‘Frequently Asked Questions’ and ‘Resources’.

**AND**

**B. General Components**

In addition to a documented medical diagnosis of a physical impairment, the student must demonstrate that the physical impairment is adversely affecting educational performance. If a student’s physical impairment does not impact academic performance or functioning in the educational setting, he/she may not need special education services. The physical impairment
must result in one or more of the following: lack of functional level of organizational or independent work skills, or inability to manage or complete motoric portions of classroom tasks within time constraints, or a 1.0 standard deviation academic achievement deficit.

The pupil’s:

(1) need for special education and services is supported by a lack of functional level of organizational or independent work skills as verified by minimum of two or more documented, systematic observations in daily routine settings, one of which is completed by a physical and health disabilities teacher;

A licensed Physical/Health Disabilities (P/HD) teacher must be included in all evaluation planning, be part of the evaluation team, and complete a minimum of one of the systematic, documented observations. The routine settings can include the classroom and other school areas (lunchroom, hallways, gym, bathroom, and playground) as well as other educational environments such as a daycare/preschool setting, residential program, vocational setting, hospital, or home. A lack of functional level of organizational or independent work skills related to the medical diagnosis can be verified through observation(s), checklists and/or interviews with school staff and the student. Organizational and Independent Work Skills/Motor Skills Checklists for infant/toddler, prekindergarten- kindergarten, elementary, middle school/high school and transition-age students are included in this manual.

or

(2) need for special education instruction and service is supported by an inability to manage or complete motoric portions of classroom tasks within time constraints as verified by a minimum of two or more documented, systematic observations in daily routine settings, one of which is completed by a physical and health disabilities teacher;

As in (1), at least one of the documented systematic observations for this verification should be completed by a licensed P/HD teacher, with additional observation(s) completed by other team members such as a special education teacher, school psychologist, Developmental Adapted Physical Education (DAPE) instructor, or school-based occupational and/or physical therapist. The classroom is not exclusive to the traditional academic instructional setting but includes all educational environments. As noted earlier, Organizational and Independent Work Skills/Motor Skills Checklists for student age/grade levels are included in this manual, and can be used to document needs in this area. The inability to manage or complete motoric portions of classroom tasks within time constraints refers to typical classroom expectations and may be due to difficulty with the following:
- strength/endurance
- coordination
- manipulating/storing/retrieving academic materials and/or tools
- handwriting difficulty with speed, legibility, fatigue, volume of writing
- making transitions within the classroom or building
- managing belongings (coat, backpack)
- activities of daily living
- developmentally appropriate play activities

or

(3) The physical impairment interferes with educational performance as shown by an achievement deficit of 1.0 standard deviation or more below the mean on an individually administered, nationally normed standardized evaluation of the pupil's academic achievement.

The deficit should be in more than one subtest of an academic achievement test. A student who meets the criteria and qualifies for special education services under the Physically Impaired category does not need to qualify for academic services due to a discrepancy between intellectual and achievement or grade placement. The evaluation should include a description of the educational implications of the achievement deficit. This information may be helpful in validating specific academic instructional needs. A licensed P/HD teacher is required to be involved in the interpretation of the evaluation results and the determination of educational needs.
PHYSICALLY IMPAIRED CRITERIA CHECKLIST

STATE DEFINITION
“Physically Impaired” means a medically diagnosed chronic, physical impairment, either congenital or acquired, that may adversely affect physical or academic functioning and result in the need for special education and related services.” Minn. R 3525.1337, subp. 1

CRITERIA
A pupil is eligible and in need of special education instruction and services if the pupil meets the criterion in item A and one of the criteria in item B.

A. There must be documentation of a medically diagnosed physical impairment:

______________________________________________________________________

Diagnosis/Physician’s name/Date

B. The pupil’s:

☐ 1) Need for special education instruction and service is supported by a lack of functional level in organizational or independent work skills as verified by a minimum of two or more documented, systematic observations in daily routine settings, one of which is completed by a physical and health disabilities teacher;

Document systematic observations in daily routine settings, one of which is completed by a teacher licensed in the area of physically handicapped or physical and health disabilities.

______________________________________________________________________

Observation 1: Who/Where/Date

______________________________________________________________________

Observation 2: Who/Where/Date
or

☐ 2) Need for special education instruction and service is supported by an inability to manage or complete motoric portions of classroom tasks within time constraints as verified by a minimum of two or more documented, systematic observations in daily routine settings, one of which is completed by a physical and health disabilities teacher;

Document two or more systematic observations in daily routine settings, one of which is completed by a teacher licensed in the area of physically handicapped or physical and health disabilities.

Observation 1: Who/Where/Date

Observation 2: Who/Where/Date

or

☐ 3) Physical impairment interferes with educational performance as shown by an achievement deficit of 1.0 standard deviation or more below the mean on an individually administered nationally normed standardized evaluation of the pupil’s academic achievement.

*Attach documentation of the physical impairment, the observation data, and/or achievement test results.
Part III

Related Laws and Regulations
To best understand the provision of services at a local level, it is critical to first understand the federal and state education laws and regulations that guide all services in the schools.

**Section 504 of the Rehabilitation Act of 1973**

Section 504 of the Rehabilitation Act of 1973, with amendments in 1986, is a civil rights law protecting the rights of individuals of all ages with disabilities participating in programs that receive federal financial assistance from the U.S. Department of Education. Section 504 defines a person with a disability as “any person who has a physical or mental impairment which substantially limits one or more of the major life activities, has a record of such impairment, or is regarded as having such impairment” [34 C.F.R. 104.3(j) (1)]. Students whose disability does not adversely affect their educational performance but substantially limits one or more major life activities may be eligible for accommodations under Section 504. This definition is broader than IDEA, which defines specific disabling conditions. The U.S. Department of Education has not defined the term "substantial limitation," allowing local educational agencies to develop their own definitions.

Some students with disabilities may not meet the eligibility guidelines under IDEA, but are qualified under Section 504. There may also be students who have a disability according to both definitions but do not require special education services. For example, some students who use wheelchairs may be qualified under both definitions, but they may not require special education services, and only require special accommodations under Section 504.

The Office for Civil Rights (OCR), U.S. Department of Education, is the enforcing agency for Section 504 in the education environment. OCR conducts compliance reviews and investigates complaints. Section 504 includes administrative complaint procedures, which can help to avoid costly court actions. Like IDEA, Section 504 requires identification, evaluation, provision of appropriate services, notification of parents, an individualized accommodation plan (Section 504 plan), and procedural safeguards. These activities must be performed in accordance with Section 504 regulations, which have some requirements that differ from those of IDEA.

For more information, refer to the MN Department of Education Compliance Manual on Section 504 of the Rehabilitation Act of 1973, revised in November of 2010 and available on MDE’s website.
**The Americans with Disabilities Act**
The Americans with Disabilities Act (ADA), originally passed in 1990 and reauthorized in 2010, is a civil rights law protecting the rights of individuals of all ages with disabilities participating in public and private programs, unlike Section 504 of the Rehabilitation Act, which only applies to public programs. The definition of a person with a disability is the same for ADA and Section 504 of the Rehabilitation Act. Educators should be aware of the need for reasonable accommodations for students in all community, vocational, and post-secondary settings.

**Individuals with Disabilities Education Act (IDEA 2004)**
IDEA is the federal law that outlines the provision of special education services for children with disabilities, and was most recently revised in 2004. This law mandates school districts to provide a free and appropriate public education to all children (FAPE), including the provision of special education and related services to children with disabilities. It also defines the requirements for identifying children suspected of having a disability, and the process of implementing special education services. The federal education laws and regulations provide the basis for our state education laws and regulations. State laws and regulations cannot be more restrictive than federal laws.

**The Family Educational Rights and Privacy Act (FERPA)**
The Family Educational Rights and Privacy Act (FERPA) protect the rights of the student and family regarding confidentiality of health and educational information. The Act allows the parent or eligible student the right to inspect and review the student’s education records; to request an amendment of the records to ensure that they are accurate, not misleading, or otherwise in violation of the student’s privacy or other rights; and to know who, besides the parents and authorized school personnel, has access to this information.

Educators need to obtain signed parent and/or legal guardian permission for exchange of information with any outside agency, such as medical facilities, physicians, therapists, and county agencies. Permission needs to be renewed yearly, and the parents have the right to rescind this permission at any time. FERPA allows disclosure of information to other school officials within the agency or institution, including teachers, who have been determined to have legitimate educational interests.
Minnesota Administrative Rules
An administrative rule is a general statement adopted by an agency to make the law it enforces or administers more specific, or to govern the agency's organization or procedure. Minnesota has a number of Rules that govern how we provide educational services to students.

Regular Education: "Regular education program" means the program in which the pupil would be enrolled if the pupil did not have disabilities. (M.R.3525.0210 Subp. 38.)

Special Education: "Special education" means any specially designed instruction and related services to meet the unique cognitive, academic, communicative, social and emotional, motor ability, vocational, sensory, physical, or behavioral and functional needs of a pupil as stated in the IEP. (M.R. 3525.0210 Subp. 42.)

Assistive Technology
The Assistive Technology Act of 2004 (and previous to that, 1998) affirms that technology is a valuable tool that can be used to improve the lives of individuals with disabilities, and has taken on an increasingly important role in all aspects of society. The Act recognizes the substantial progress that has been made in the development of AT devices in recent years, supports statewide technology programs and initiatives, and strengthens the capacity of each state to address the assistive technology needs of individuals with disabilities. States are required to conduct the following activities: Support public awareness programs; promote interagency coordination; provide technical assistance and training; and provide outreach and support to community-based organizations that provide assistive technology devices, adaptations, or services.

Definition of an AT Device: IDEA defines an assistive technology device as ‘any item, piece of equipment, or product system, whether acquired commercially or off the shelf, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of a child with a disability. The term does not include a medical device that is surgically implanted or the replacement of such device’ (IDEA 2004, Sec 300.5)
**Definition of AT Service:** Assistive technology service means any service that directly assists a child with a disability in the selection, acquisition, or use of an assistive technology device. The term includes:

- The evaluation of the needs of a child with a disability, including a functional evaluation of the child in the child's customary environment;
- Purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices by children with disabilities;
- Selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;
- Coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing education and rehabilitation plans and programs;
- Training or technical assistance for a child with a disability or, if appropriate, that child's family; and
- Training or technical assistance for professionals (including individuals providing education or rehabilitation services), employers, or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of that child.

(IDEA 2004, Sec 300.6)
Part IV

Role of the P/HD Teacher
Who is the Physical/Health Disabilities Teacher?
For purposes of clarification, the current teacher licensure title is ‘Physical and Health Disabilities’ (P/HD), and the special education category is ‘Physically Impaired’ (PI). The student who receives special education services under the Physically Impaired category must have a licensed teacher in this special education area as a member of his/her IEP team. This teacher must be involved in the evaluation and development of the IEP for the student receiving services under the category of Physically Impaired. This is defined in MN Rule 3525.2350, Multi-disability Team Teaching Models:

Subp. 2. **License requirement.** There must be a teacher on the team who is licensed in the disability area of each pupil served by the team.

Subp. 3. **Team member responsibility.** The team member licensed in a pupil’s disability shall be responsible for conducting the pupil’s evaluation and participating at team meetings when an IEP is developed, reviewed, or revised. Consultation and indirect services as defined in part 3525.0210 must be provided to the general or special education teacher providing instruction if not licensed in the disability. The frequency and amount of time for specific consultation and indirect services shall be determined by the IEP team.

Although a documented disability category is unknown at the time of a student’s initial evaluation, the intent of the law would suggest that an evaluation team should include a P/HD teacher if student records and presenting needs indicate the presence of a physical impairment.

Currently, the Minnesota P/HD license granted to teachers working with students who meet criteria under the Physically Impaired category covers students from birth to age 21.

**Serving Students Who Qualify Under Other Categories**
Although there is currently no special education teacher licensure specific to OHD or TBI, Hamline University in St. Paul does offer graduate level certificates in these areas. Curriculum development for these certificates was made possible through grant funding from the MN Low Incidence Projects. If P/HD teachers have sufficient training and experience and/or have received certification in either of these areas, they may be identified as service providers for students who qualify under these categories. However, it should be noted that, in the case of Other Health Disabilities (OHD), employing districts may recommend that P/HD teachers primarily serve students who have chronic and/or acute health conditions.

For information on roles of other team members, see Part X.
8710.5800 TEACHERS OF SPECIAL EDUCATION: PHYSICAL AND HEALTH DISABILITIES.

Subpart 1. Scope of practice. A teacher of special education: physical and health disabilities is authorized to provide specialized instructional services in prekindergarten through grade 12 to children and youth with medically diagnosed physical or health disabilities and to collaborate and consult with families, other classroom and special education teachers, and specialized service providers in designing and implementing individualized educational program plans for students.

Subpart 2. License requirements. A candidate for licensure to teach prekindergarten through grade 12 students with physical or health disabilities shall:

A. hold a baccalaureate degree from a college or university that is regionally accredited by the association for the accreditation of colleges and secondary schools;

B. demonstrate the standards for effective practice for licensing of beginning teachers in part 8710.2000;

C. demonstrate core skill requirements in part 8710.5000; and

D. show verification of completing a Board of Teaching preparation program approved under part 8700.7600 leading to the licensure of teachers of special education: physical and health disabilities in subpart 3.

Subpart 3. Subject matter standard. A candidate for licensure as a teacher of special education: physical and health disabilities must complete a preparation program under subpart 2, item D, that must include the candidate's demonstration of the knowledge and skills in items A to E.

A. A teacher of special education physical and health disabilities: understands the central concepts, tools of inquiry, and history and context of physical and health disabilities as a foundation on which to base practice. The teacher must understand:

(1) historical and philosophical foundations, legal bases, and contemporary issues pertaining to services to and the education of children and youth with medically diagnosed physical or health-related disabilities;
(2) the etiology, characteristics, and classification of physical and health-related disabilities and their developmental and educational implications on children and youth;

(3) current educational definitions, identification criteria and labeling issues, and entrance and exit criteria for services pertaining to students with physical or health-related disabilities;

(4) implications of physical and health disabilities on psychosocial, educational, vocational, and leisure outcomes for students;

(5) basic principles of human anatomy, physiology, pharmacology, kinesiology, and neurology;

(6) secondary health care issues which accompany specific physical and health disabilities;

(7) condition-specific needs as these needs relate to managing personal physical care for children and youth with physical or health disabilities;

(8) appropriate body mechanics to ensure student and teacher safety in transferring, lifting, positioning, and seating;

(9) first aid techniques and evacuation procedures necessary to maintain the safety of students in a variety of educational settings;

(10) how to assess reliable methods of response of individuals who lack typical communication and performance abilities;

(11) how to apply recommended universal precautions to maintain healthy environments; and

(12) common environmental and structural barriers that hinder accessibility and acceptance of individuals with physical and health disabilities.
B. A teacher of special education physical and health disabilities: understands referral, assessment, planning and placement procedures specific to teaching students with physical or health related disabilities. The teacher must understand:

(1) referral and intervention procedures;

(2) use, limitations, ethical concerns, administration and interpretation of formal and informal assessment for students with a physical or a health disability and how to effectively communicate the results to the students, families, teachers, and other professionals;

(3) how to adapt and modify existing assessment tools and methods to accommodate the unique abilities and needs of students with physical or health disabilities;

(4) major assessments used to measure motor, auditory, visual, and other learning modalities, and how to adapt and modify assessment measures appropriately for children and youth with physical or health disabilities;

(5) how to assess student need for and the ability to use assistive or adaptive technology;

(6) how to assess the functional skills of children and youth with a physical or health disability;

(7) how to assess for environmental and structural barriers;

(8) school setting adaptations necessary to accommodate the needs and abilities of children and youth with physical or health-related disabilities;

(9) how to interview, gather, and maintain information from parents, families, teachers, and other professionals for purposes of assessment and planning, developing, implementing, and evaluating educational services to students with physical or health disabilities;

(10) communication and social interaction alternatives for individuals who are nonverbal;

(11) uses and sources of appropriate materials, equipment, and adaptive, augmentative, and assistive technologies to meet the needs of children and youth with physical or health disabilities;
(12) various educational placement options and the selection of appropriate options based on the needs of the student;

(13) how to develop and use technology plans based on adaptive technology assessment and integrate these plans into the individual educational program plans; and

(14) how to design individual plans that integrate assessment-based needs results and family priorities, resources, and concerns; and that incorporate, when appropriate, academic and nonacademic goals and the appropriate use of augmentative, adaptive, and assistive technologies.

C. A teacher of special education physical and health disabilities: understands how to use individual education program plans to design and implement developmentally appropriate instruction for students with physical or other health-related impairments. The teacher must understand how to:

(1) interpret sensory, mobility, reflex, and perceptual information to create appropriate learning plans for children and youth with a physical or health disability;

(2) implement research-supported instructional practices, strategies, and adaptations necessary to accommodate the unique needs of students with physical or health disabilities;

(3) adapt, modify, and accommodate curriculum or teach compensatory skills to optimize learning for children and youth with physical or health disabilities;

(4) apply the knowledge of fine-, gross-, and sensori-motor development to curriculum selection and design;

(5) construct instructional sequences to teach transition skills based on the cognitive, affective, and academic strengths of each student and plans for transition from school to postsecondary training and employment;

(6) apply strategies for teaching self-advocacy; and

(7) monitor, summarize, and evaluate the acquisition of the outcomes stated in the individual plans.
D. A teacher of special education physical and health disabilities: communicates and interacts with students, families, other teachers, and the community to support student learning and well-being. The teacher must understand:

1. how to assist students and their parents in making choices that impact academic and occupational decisions;

2. sources of unique services, networks, agencies, and organizations for students with physical or health disabilities;

3. roles and responsibilities of related services personnel, including physicians, nurses, occupational therapists, physical therapists, prosthetists, rehabilitation engineers, and adapted physical education teachers in the education of students with physical or health disabilities;

4. educational roles and responsibilities of other teachers and support personnel in providing educational services to students with physical or health-related disabilities;

5. processes and strategies for providing integrated care for children and youth with a physical or health disability, particularly when students are transitioning from home, hospital, or rehabilitation facility to school; and

6. how to access information relevant to the field of physical or health disabilities through consumer and professional organizations, publications, and journals.

E. A teacher of special education physical and health disabilities: applies the standards of effective practice in teaching students with physical or health disabilities through a variety of early and ongoing clinical experiences with prekindergarten, kindergarten or primary, intermediate or middle level, and high school students across a range of service delivery models.

Subpart 4. Continuing licensure. A continuing license shall be issued and renewed according to rules of the Board of Teaching governing continuing licenses.

Subpart 5. Effective date. Requirements in this part for licensure as a teacher of special education: physical and health disabilities are effective on September 1, 2001, and thereafter.
Part V

Referral & School Re-Entry
**Referral**
The referral process for students with physical impairments can be unique due to pre-existing chronic physical/health needs. Referrals can come from a variety of sources, including parents, teachers, school nurses, or the medical/rehabilitative communities. A referral must include medical documentation of a diagnosed physical impairment written by a physician, and should be kept in the student’s school file. In addition to having a documented medical condition, the student must also demonstrate educational needs related to the medical diagnosis.

**School Re-Entry**
A child or youth may sustain a severe injury, resulting in hospitalization and long term physical impairment; or a child with an existing physical impairment may require hospitalization for an extended period of time for surgeries. The recovery process for either situation is often a long and arduous one for the child and family. It is very important that the health care professionals, parents and school staff work closely together through-out this period to ensure a smooth re-integration between hospital, home, and school.

**Recent Injury**
Prior to the student’s return to school, the team must determine if the student is eligible for and in need of accommodations related to the physical impairment, which can be provided through implementation of a 504 plan or an IEP, depending upon the degree of educational need. If a special education evaluation is warranted and the student qualifies for special education, services under the disability category of Physically Impaired would likely be considered. All due process procedures must be completed prior to the initiation of special education services, including the evaluation, determination of eligibility, and IEP. Frequently, the special education evaluation will be initiated while the student is still in the hospital or rehabilitation setting. Documents and assessment results provided by the medical team should be included in the data gathered through the evaluation process. In the event that the evaluation and special education qualification cannot be completed prior to school re-entry, appropriate school services must be provided through general education funding, i.e. transportation, ADL support, nursing services, homebound instruction, etc.

If the student has been discharged from the medical facility and has returned home, the evaluation process may conclude in the home setting. Observations, which are an important component of an evaluation, should occur in the setting where the child is residing. Multiple observations may need to be conducted as the child transitions between settings. Evaluation timelines may be impacted by the student’s rate of recovery and availability for evaluation.
activities. If the student is scheduled to return to school prior to the 30 school day evaluation timeline, the team may need to expedite the evaluation in order to provide the student with a safe and appropriate program and services upon re-entry to school. Ongoing evaluations may be needed as the student’s recovery continues. The documents included in this section are suggested guidelines for completing this process. A medical discharge documentation form and re-entry protocol is included on the following page.

Note: The following forms can also be found in the Appendices section of this manual.
Students with Physical Impairments:  
Suggested Protocol for Initial Evaluation Following Hospitalization

Student: ____________________ Date of Birth: ________________________________

School/Grade: ______________________________________________________________

Date of Injury/Hospitalization: _______________________________________________

Type of Injury ______________________________________________________________

Parent Name/Phone #: ________________________________________________________

Collaboration between all involved partners- the hospital, school and family- is critical when a child or youth with a significant physical impairment is transitioning between the hospital or rehabilitation setting, the home, and school. The following protocol, with family involvement and permission, is recommended, as these students typically require accommodations and/or modifications in the educational setting.

A timely return to school is beneficial. Schools can customize a student's day to ease the transition and accommodate ongoing medical needs such as pain, fatigue, and medication side effects.

• **Following Admission to the Hospital**
  Once a parent or hospital representative has contacted the school district, a school representative (P/HD Teacher, special education case manager, or school nurse) is assigned as the contact person by the administrator. The school representative will:

  □ Contact parent(s) to Inquire about their child’s condition and determine how and what information will be shared with school community

  □ Obtain a release of information if one is not in the school file.

  **Note:** A signed Release of Information form must always be kept in student’s file.

  □ If a recent injury, initiate discussion about the evaluation process

  □ Contact the child’s caseworker at the hospital to:
    - Initiate discussion about the evaluation process
    - Discuss school re-entry issues/questions
☐ Meet with the child’s classroom teacher(s) and education staff to inform them of child’s condition

☐ Obtain and review current educational records to be shared with hospital team

- **After student’s condition has stabilized**, the school representative will contact the hospital case manager to:
  - Obtain information regarding the child’s condition
  - Determine if/when to send schoolwork

- **Prior to discharge from the hospital**, the school representative/team will:
  - Visit with student and hospital/rehabilitation staff
  - Determine need for special education evaluation, and initiate if appropriate
  - Obtain copies of current hospital evaluations and documentation of the medical diagnosis of the physical impairment
  - Arrange and/or conduct school in-service to:
    - Provide specific information about the student’s condition
    - Provide general information about the physical impairment
    - Discuss potential modifications, i.e., ramp, wheelchair, transportation, ADL support, classroom support
  - Contact parent(s) to:
    - Determine when/if the child will be getting post-acute rehabilitative care
    - Establish a date for return to school
  - Follow-up with hospital case manager; get updates on discharge plan and needs
☐ Recent injury: Conclude special education evaluation, determine eligibility, and (if appropriate) develop IEP

☐ Student with an existing IEP: Modify IEP and accommodations to reflect current needs

☐ Develop additional plans as needed (Individual Health Plan, Emergency Care Plan, Emergency Evacuation Plan)

• **After the first weeks at school,** the team will:

  ☐ Re-evaluate the student’s needs and modify IEP accordingly

  ☐ Maintain collaboration with parents, teacher(s), and medical personnel
Students with Physical Impairments: For Students with Existing IEPs
Following Medical Procedure/Hospitalization

(To be completed by medical staff. Send one copy home with family at discharge and fax copy to child’s school prior to discharge, assuming a release of information has been signed.)

Child’s Name: ___________________________ Date: ____________________________

Medical Record Number: ___________ Date of Birth: ____________________

This child has been hospitalized from ______to ____________ due to medical procedures related to his/her medical diagnosis. Specific information and recommendations regarding a return to school or a childcare program are documented below.

Follow-up visit or procedure will occur on:

Resume school/childcare program (Check one): ☐ homebound ☐ half day ☐ full day
Duration (Give dates): ________________________________________________
_________________________________________________________________

Changes in medication and possible side-effects to monitor: ____________________

Transportation (Check one):

☐ regular ☐ lift bus ☐ bus seat belt ☐ direct adult supervision

Please specify duration of bus ride permitted and date for possible review: _________
_________________________________________________________________

Physical Education Class (Check one): _______ resume regular class _______ modify
If modified, please list restrictions ________________________________________
_________________________________________________________________

Contact sports (Check one): _______________ resume ________________ modify
If modified, please list restrictions ________________________________________
_________________________________________________________________

Presenting educational problems resulting from medical procedure:
_________________________________________________________________
Students with Physical Impairments: For Students with Existing IEPs Following Medical Procedure/Hospitalization, continued

Please identify restrictions related to weight-bearing and transfers:
__________________________________________________________________________

Specific recommendations related to ROM and other stretching activities:
__________________________________________________________________________

Specific recommendations related to time in and out of wheelchair:
__________________________________________________________________________

If additional information is needed about this child’s return to school or childcare, contact:

Name ______________________________________

Phone _____________________________________

Email _____________________________________
Part VI

Evaluation & Eligibility
Overview
Evaluating students with physical impairments can pose many challenges, and results can often affect eligibility for services and educational programming. In order to be considered eligible for special education services, a student must have a documented medical diagnosis of a physical impairment that adversely affects his/her academic functioning. An evaluation is conducted by a team of special educators to identify existing educational needs as they relate to the impairment. If a student has recently been evaluated in a clinical or medical setting and the information is pertinent to the student’s educational program, this information should be considered and incorporated into the school evaluation.

The special education evaluation team must include a licensed Physical/Health Disabilities teacher. In addition to the parent(s) or guardians, other team members may include other licensed special education teachers, a physical and/or occupational therapist, speech/language pathologist, school nurse, school psychologist, DAPE teacher, and other appropriate related service providers.

Traditional psychometric tests may provide useful information, but must be used with caution as test scores may not reflect the student’s educational needs and/or abilities. The student’s ability to demonstrate typical academic or learning tasks in the classroom and educational environment should be carefully evaluated. In addition to the more traditional academic testing, student observations should also focus on the following areas: Organization of materials, time management, work completion, attending skills, communication skills, functional motor skills, and endurance.

As a result of a student’s potential fluctuation in his/her medical status, ongoing monitoring and revisions to the student’s instructional program, IEP and accommodations may be required more frequently than with other students.
**Eligibility Determination**

To determine eligibility for qualification of special education services under the Physically Impaired category, a team must first assure that a physician has provided written medical documentation of the physical impairment, which is then kept in the student's school file. The team must then verify that there are educational needs related to the diagnosis that adversely affect the student's educational performance, determined through a comprehensive special education evaluation conducted by a multiple disciplinary team. Members of such a team can include (but not limited to) the following individuals: A Physical/Health Disabilities teacher, special education teacher, school nurse, school psychologist, DAPE teacher, occupational and/or physical therapist, speech/language clinician, or other appropriate related service providers. The eligibility criteria for PI as documented in Minnesota Rule 3525.1337 can be found in this manual.

**LINKING THE MEDICAL DIAGNOSIS TO ELIGIBILITY AND EDUCATIONAL NEEDS**

When determining eligibility under the category of Physically Impaired, the evaluation team must link the medical diagnosis to the criteria components, including (1) a lack of functional level in organizational or independent work skills; (2) an inability to manage or complete motoric portions of classroom tasks within time constraints; and/or (3) a demonstrated achievement deficit.

**Example:**

**Criteria**

B. The pupil's:

1. need for special education instruction and service is supported by a lack of functional level in organizational or independent work skills as verified by a minimum of two or more documented, systematic observations in daily routine settings.

**Student Profile**

Damita has a medical diagnosis of myelomeningocele (spina bifida) with treated hydrocephalus. Her diagnosis has resulted in lower extremity paralysis, visual-perceptual problems, reading comprehension difficulties, and distractibility. Damita requires adult assistance in order to understand task directions. She requires frequent prompts (at least one every two minutes) to continue working on classroom assignments. Damita needs to improve her independent work skills.
**Goal:**
Damita will improve her independent work skills, from a level of relying on adults to restate and explain task directions, to a level of checking for understanding and seeking clarification independently through small group instruction.

**Objective 1:**
Given a classroom assignment and a verbal prompt to identify the essential details in the directions, Damita will correctly underline the task directions and explain what the directions require her to do; demonstrated in 9 of 10 trials as monitored by selected school staff using a data sheet.

**Objective 2:**
Given a classroom assignment, Damita will independently underline the task directions and accurately explain what the directions require her to do; demonstrated in 9 of 10 trials as monitored by selected school staff using a data sheet.

**Objective 3:**
Given assignment directions that she does not understand, Damita will independently seek assistance from an adult or a peer in the classroom; demonstrated in 9 of 10 trials as monitored by selected school staff using a data sheet.

**ISSUES TO CONSIDER WHEN CONDUCTING AN EVALUATION**

When evaluating a student with a physical impairment, the following indicators should be carefully observed and noted within the evaluation report.

**Potential Neurological Indicators**
- Distractibility, poor concentration, and poor impulse control (disinhibition)
- Memory difficulties that affect encoding, retention, and retrieval of information
- Visual-spatial problems affecting part-whole reasoning, integration of thoughts, and synthesis
- Conceptual reasoning and organizational skills
- Slow processing speed and slowed output of information, affecting performance in timed tests.
**Motor Ability Indicators**

**(Gross Motor)**
- Extreme weakness or total paralysis of one or both sides
- Reduced muscle tone (hypotonia) or rigidity
- Muscle contractions or spasticity
- Poor balance or ataxia

**(Fine Motor)**
- Reduced motor dexterity and tremors, impairing the ability to cut with scissors, draw, or handwrite
- Problems with motor planning (dyspraxia), impairing the ability to do self-care or some vocational activities

**Oral Motor Indicators**
- Oral motor dysfunction affecting articulation and/or swallowing

**Visual Indicators**
- Visual field cuts (blind spots or areas)
- Impaired visual tracking (affecting reading, writing, navigating in unfamiliar environments)

**Health/Physical Indicators**
- Physical limitations (restrictions from physical education, fatigue/endurance issues)
- Medical concerns (seizures, headaches, pain, dizziness, vertigo)
- Medication issues (anticonvulsant, anti-depressant, psycho-stimulant medications)
- Requires assistive devices (wheelchair, positioning equipment, assistive technology)
ADAPTATIONS TO EVALUATIONS: ACCOMMODATING LEARNERS WITH PHYSICAL IMPAIRMENTS

Alternative presentation format
- Reading directions or text
- Presenting complex directions in smaller, sequential increments
- Teaching the test responses

Modification of test materials or administration
- Limiting the amount of test items presented
- Enlarging test items or making the test clearer perceptually
- Rearranging test items
- Providing time extensions or eliminating time variable
- Allowing shortened test sessions or more frequent breaks

Alternative response formats
- Pointing
- Eye-gazing
- Dictating response
- Interpreting of response by person familiar with learner's communication
- Using an augmentative communication device
- Changing to multiple-choice format
- Enlarging the test protocol to provide more space for writing
- Using word processing to complete writing tasks or tests, if appropriate
- Using compensatory software such as word prediction, voice input, or text to speech
- Using calculator

If adaptations are used in test administration, these need to be documented in the discussion of the test results and interpretation. Many of these adaptations would result in a significant change in the administration and standardization of the test. The validity of the results needs to be carefully weighed when making educational decisions.

Evaluating the intellectual functioning of a student with a physical disability is often complicated by the student's motor skills. Even though the performance section scores may be invalid due to the significant changes required for administration, the performance portions could be completed to gain insight into the student's problem solving skills and information processing.
There are several cognitive tests that do not require a verbal response or motor response (except to point):

- Test of Non-Verbal Intelligence III (TONI)
- Comprehensive Test of Non Verbal Intelligence

*There are specific accommodations in the following areas; presentation format, test setting, scheduling and timing, and response format for Minnesota State Basic Standards and Statewide Testing.

SUGGESTIONS FOR EVALUATING READING COMPREHENSION OF NON-VERBAL STUDENTS WITH PHYSICAL IMPAIRMENTS

For beginning readers who are non-verbal, it can be challenging to develop strategies to determine if the student is able to identify the word. While it is sometimes very helpful initially to have the student’s reading words included in the student’s communication system, it would not be realistic to have the student learn to say every word that he or she can read.

- Always encourage the beginning reader to identify words that are unknown, so they will be correctly identified and practiced.
- Have the student read a passage with a purpose; “Read to find out.............”

For beginning readers, check for literal comprehension by asking questions related to detail and vocabulary. Inferential, sequential, and predictive questions are more difficult due to the communication and written language skills of beginning, nonverbal readers.

The student may be able to demonstrate knowledge of words through different questioning strategies. While yes/no responses are fast and easy, when used for identifying reading words the student has a 50-50 chance of correctly identifying the word. Some examples of varied questions that could be asked that would be more likely to determine if the student knows a word could be:

- What word means the same as......?
- What word means the opposite of........?
- What word has three syllables? What are two words with two syllables?
- What word rhymes with........?
- What word would fit is this sentence? (Fill in the blank, cloze sentence)
Other ideas could include using color or multiple choice strategies to allow students to identify the words. For example, words in the text could be highlighted different colors, and the student could identify the color of the correct word using informal or formal communication systems. If the student has the motor skills to point to a specific word, consider enlarging the text to allow the student to touch the requested word.

For some stories, the pictures in the story can be used to help identify vocabulary. The student could point to the word, then tell what an object is in the picture, or point to the part of the picture that is labeled by a particular vocabulary word. Depending on the skill level of the student using his or her communication device, reading vocabulary could be practiced by asking the student to name one or more words on the page that can be said with his or her device. Other ideas for determining the level of reading comprehension would be to utilize commercially available multiple-choice format materials such as reading series placement or progress evaluations, reading materials such as Barnell-Loft or SRA, or formal evaluation instruments such as the Stanford Diagnostic Reading Test or Gates-McGinty Reading Test.

INFORMAL EVALUATION
When evaluating students with physical impairments, the informal evaluation process is one of a number of multi-method assessment procedures, and is of particular importance due to the difficulties encountered in traditional testing of students with a physical impairment. The presented purpose is to provide the Physical/Health Disabilities teacher and the student’s respective educational team a set of acceptable informal techniques that should be considered during the evaluation process. Identifying students who have physical impairments as eligible and in need of special education services typically requires norm-referenced testing, while evaluations conducted for educational planning purposes utilize a variety of assessment procedures which may or may not include traditional norm-referenced testing.

The purpose of conducting an informal evaluation:
- When atypical motoric and/or verbal responses do not allow the use of standardized measures
- Confirm or dispute information obtained from other formal and objective evaluation procedures
- Collect data not addressed or available with other formal assessment measures
- Obtain informal information on how the student functions relative to his/her physical impairment in various settings
Informal evaluations include:

- Review of the student’s cumulative school records
- Systematic observations
- Trial use of various assistive technology devices to establish reliable methods of response
- Parent, teacher and/or student interviews
- Data collected from permanent records, such as:
  - The number of times homework is turned in, completed/correct/on time
  - Student performance on weekly spelling tests, etc.
  - Student performance on curriculum unit tests
  - Student grades on assignments
  - Student report card grades
  - Student work samples
- Student portfolios compiled by the P/HD teacher that show progress over time, i.e., Compensatory Skills Checklist for Students with Physical Impairments
- Objective staff comments and observations
- IEP periodic review statements

**What is a systematic observation?**

A systematic observation occurs in the natural setting of the student, typically his/her classroom, and requires the teacher to observe behaviors relative to the student’s educational functioning. The collected data requires the teacher to explain how the student’s impairment is affecting his/her classroom functioning by quantifying the behavior and providing information on frequency, rate, latency etc. in an objective, data-specific reporting format.

**Why are systematic observations conducted?**

A systematic classroom observation by a P/HD teacher is one of the eligibility components in the Minnesota Criterion for Physically Impaired (MR 3525.1337).

Subp. 2, Section B (1) states: “The pupil’s need for special education instruction and service is supported by a lack of functional level in organizational or independent work skills as verified by a minimum of two or more documented, systematic observations in daily routine settings, one of which is completed by a physical/health disabilities teacher…”

Systematic observations provide the P/HD teacher with specific data to assist the student’s team in educational planning and to supplement other norm-referenced tools.

Statements of current performance included in the Individual Educational Plan (IEP) require the student’s educational team to address the student’s progress in the general education curriculum. Systematic observations provide data that can be included in these statements.
When are systematic observations conducted?

- For initial and three year re-evaluations on students
- When there are concerns about a student’s progress
- When there are concerns about how much, or to what degree, a student is accessing information in an education setting
- When the team is concerned about what strategies the student utilizes during breakdowns in learning
- When the student’s educational team is determining or modifying IEP accommodations or adding services (i.e. electronic note-taking, a paraprofessional, etc.)
- When a parent or a member of a student’s IEP team request an observation to address a specific issue or concern
- When there are considerations to add, change, or remove a student’s current school-based assistive technology
- When there are concerns about the placement and/or setting of the student

Note: Some of the above information taken from: Informal Assessments; Minnesota D/HH Manual
EVALUATING INFANTS AND CHILDREN AGED BIRTH TO FIVE WITH PHYSICAL IMPAIRMENTS

Physical/Health Disabilities teachers are licensed to serve students aged birth to 21 years of age, and may be asked to evaluate and serve an infant or toddler with a documented physical impairment. Typically, services provided to an infant or toddler by a P/HD teacher are indirect, and involve consultation to the family and other team members. Areas of focus often include environmental access, adaptations and/or modifications to toys, equipment, and preschool curriculum, assistive technology, and community and electronic resources specific to the child’s disability.

When evaluating an infant or toddler with a physical impairment, the State criteria may need to be interpreted in such a way that it applies to their unique educational environment. The chart below may offer some helpful suggestions when attempting to translate the criteria and determine eligibility for this age group.

<table>
<thead>
<tr>
<th>PI Criteria Sub-Item B</th>
<th>Language from Rule</th>
<th>Interpretation for children Birth to Five</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Lack of functional level in organizational or independent work skills</td>
<td>Lack of functional level in developmentally/age appropriate organizational or independent play skills</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Inability to manage or complete motoric portions of classroom tasks within time constraints</td>
<td>Inability to manage or complete motoric portions of developmentally/age-appropriate learning/play tasks within time constraints</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Physical impairment interferes with educational performance as shown by an achievement deficit of 1.0 SD or more below the mean on an individually administered nationally normed standardized evaluation of the pupil’s academic achievement.</td>
<td>Physical impairment interferes with developmental performance as shown by an achievement deficit of 1.0 SD or more below the mean on an individually administered nationally normed, standardized evaluation of the student’s achievement; using a test appropriate to the age of child being evaluated.*</td>
<td></td>
</tr>
</tbody>
</table>

Check with your ECSE coordinator for appropriate assessment tools

**NOTE:** A Categorical Disability Comparison Chart for PI, OHD, TBI & DD (birth to seven years) can be found in the appendix section of this manual.
EVALUATING STUDENTS WITH PHYSICAL IMPAIRMENTS AND DEVELOPMENTAL COGNITIVE DISABILITIES: GUIDELINES FOR SMI QUALIFICATION

Students who qualify for Severely Multiply Impaired (SMI) must meet criteria under two or more specified special education categories, one of which may be Physically Impaired. The purpose of the following information is to address the unique evaluation and service delivery needs of students who qualify for SMI under the categories of PI and DCD (Severe/Profound). Students who meet criteria under these 2 categories generally receive special education instruction and services in a variety of settings, including classroom environments which provide individualized instruction and a full service continuum of trained special education teachers and related services staff. These educators typically have extensive training and experience in working with students who have co-existing physical and cognitive impairments.

Given such settings and instructional expertise, this would suggest that the role of the P/HD teacher is best utilized through the provision of low level indirect support to the team members as it relates to:

- Identifying modifications or adaptations to allow maximum physical access to the educational environment or curriculum
- Offering suggestions on materials that may support the physical needs of the student
- Suggesting educational or community resources related to the physical impairment
- Offering a unique educational perspective gained through years of training and experience with students who have physical impairments

Low level indirect support can be defined as a service schedule that occurs quarterly, semi-annually, or annually, depending upon the student’s individual educational needs. P/HD teachers should participate in the annual IEP meeting, and serve as a member of the evaluation team when conducting re-evaluations.

Considerations for PI/SMI Qualification

1. Referrals for the inclusion of the PHD specialist in the evaluation/re-evaluation cycle should occur when the team confirms that there is documentation of a medically diagnosed physical impairment in the student’s school file. Additionally, the student is noted to have significant cognitive deficits. The PHD teacher should be included on the evaluation plan, and involved in the eligibility determination discussion.
2. If the student qualifies for special education services under the DCD-Severe/Profound and PI categories, the team shall determine that a student is eligible as being severely multiply impaired (see SMI criteria below).

3. Unless otherwise recommended, the assigned P/HD teacher would provide low-level indirect consultation services to the team such as involvement at annual IEP meetings, and consultation on issues related to curriculum or environmental access and evacuation planning. When need for a re-evaluation occurs every three years, the P/HD teacher would again be involved in that evaluation process.

4. When documenting the SMI category on the student’s IEP, it is recommended that the qualifying categories also be identified, along with supporting rationale.

(Taken from Minnesota Rules)
3525.1339 SEVERELY MULTIPLY IMPAIRED

Subpart 1.

Definition

"Severely multiply impaired" means a pupil who has severe learning and developmental problems resulting from two or more disability conditions determined by an evaluation, as defined by part 3525.2710.

Subp. 2.

Criteria

The team shall determine that a pupil is eligible as being severely multiply impaired if the pupil meets the criteria for two or more of the following disabilities:

A. deaf or hard of hearing, part 3525.1331;

B. physically impaired, part 3525.1337;

C. developmental cognitive disability: severe-profound range, part 3525.1333;

D. visually impaired, part 3525.1345;

E. emotional or behavioral disorders, part 3525.1329; or

F. autism spectrum disorders, part 3525.1325.

Statutory Authority: MS s 120.17; L 1999 c 123 s 19,20

History: 16 SR 1543; L 1998 c 397 art 11 s 3; 26 SR 657
OTHER EVALUATION TOOLS DESIGNED FOR STUDENTS WITH PHYSICAL IMPAIRMENTS

PI/HD Self Advocacy and Disability Awareness Checklist (SADAC)

The Self Advocacy and Disability Awareness Checklist is designed to be used with students who have physical impairments. It is an informal evaluation tool used to gather information regarding a student’s self-advocacy skills and disability awareness. Self-advocacy skills allow individuals to recognize individual rights and abilities, identify when help is needed, and to know when and how to appropriately ask for support. This promotes a sense of control in their world and assists in developing healthy self-esteem. This tool is designed for students from elementary through transition age, and combines two separate checklists. It allows the educator and student to identify areas of strength and need as they relate to self-advocacy and disability awareness, and how those strengths can be used to address educational needs. This tool may also be helpful in developing IEP goals, objectives, and accommodations in the educational setting.

Compensatory Skills Checklist for Students With Physical Impairments

The Compensatory Skills Checklist can be utilized by the P/HD teacher to document the progress of students with physical impairments from Pre-Kindergarten through 12th grade and/or transition programming. Its simplicity and structure lends itself to a variety of applications. Evaluation of student progress is indicated by recording the level of achievement for each individual goal. Ongoing data collection offers opportunities to periodically re-evaluate student progress and provide information that is needed for the development of instructional activities and goal development. This tool may also be helpful in providing documentation of where a student is performing in the functional skills areas, and assists in the transition process when students move from one educational setting to another.

The components of this tool include the following:

I. Understanding Disability
II. Self-Advocacy Skills/Resources
III. Use of Technology
V. Organizational/Independent Work Skills
VI. Interpersonal Skills
VII. Functional Motor Skills
These tools can be found in their entirety on the MN Low Incidence Projects PI Resources webpage. They were initially developed by the Intermediate District #287 Itinerant Physical/Health Disabilities Program for use with students who have physical and/or health disabilities.

**ORGANIZATIONAL AND INDEPENDENT WORK SKILLS/MOTOR SKILLS CHECKLISTS FOR STUDENTS WITH PHYSICAL IMPAIRMENTS**

The documents found on the following pages comprise the Organizational and Independent Work Skills/Motor Skills Checklists for students with physical impairments of all ages, and will assist the team in determining if a student meets special education criteria in the categorical area of Physically Impaired. These checklists have been carefully developed and used by Physical/Health Disabilities teachers in the field for many years, with the most recent revisions occurring in 2008. In addition to utilizing this tool in an evaluation or re-evaluation to assist in determining qualification for services, the Checklist may also provide educational team members with important data useful in developing goals and objectives in the IEP as they relate to the areas of organizational and independent work skills.

Each checklist (with the exception of the Infant/Toddler Checklist) addresses the main categories of Organizational Skills, Work Skills, and Motor Skills. A rating scale for responses includes Always/Often, Sometimes, or Rarely/Never. There is space for documenting comments and/or adaptations that are currently provided. In addition, the tool also asks the respondent to identify student strengths, behavioral concerns, social skills, and peer acceptance; and identify all accommodations and/or modifications that are currently in place for the student.

The checklist can be completed by general and special education teachers, related services staff, and parents/guardians, although many of the skill areas are most often seen in the educational setting.

The individual checklists are categorized by the following general age ranges:

- Infant and Toddler
- Pre-Kindergarten and Kindergarten
- Elementary
- Middle School/High School
- Transition (post-high school)

The introduction cover sheet and five checklists can be found in Part XVI (Appendices).
Part VII

Considerations for Service Delivery
Overview
Service delivery for P/HD teachers is often defined as consultative and itinerant, although some districts continue to utilize the direct service model to a limited extent. Service delivery models are determined at the local level. However, the general framework and definition of special education services is based on language stated in Minnesota Rules:

**Direct:** Defined as special education services provided by a teacher or related services professional when the services are related to instruction, including cooperative teaching. (M.R. 3525.0210 subp. 14)

**Indirect:** Defined as special education services which include ongoing progress reviews; cooperative planning; consultation; demonstration teaching; modification and adaptation of the environment, curriculum, materials or equipment; and direct contact with the pupil to monitor and observe. Indirect services may be provided by a teacher or related services professional to another regular education teacher, special education teacher, related services professional, paraprofessional, support staff, parents, and public and nonpublic agencies to the extent that the services are written in the pupil’s IEP or IFSP. (M.R. 3525.0210 subp. 27)

**Direct Service**
A P/HD teacher, in consultation with the IEP team, may recommend the provision of direct services to a student who has qualified for special education services under the PI category. Most often, such direct service is provided on a limited basis, and only when there is clear instructional need that is directly related to the physical impairment; and/or when there are unique instructional methods/skills required that no one else on the educational team can replicate and can only be provided by the P/HD teacher.

When providing direct services, the P/HD teacher should always consider a collaborative instruction model whenever possible, involving the educational team and classroom staff in the instructional process. This is critical, whether it involves an academic curriculum area or instruction in organizational strategies, work completion, or self-advocacy. Such collaboration and team teaching will allow a smoother transition of direct services to educational staff who are present in the classroom on a daily basis and can provide the needed instruction in a consistent and informed manner.
It is required that the team consider the service timeline for P/HD teacher services during the initial and/or annual IEP meeting and provide documentation on the IEP that clarifies when direct services begin and end, as well as providing rationale for this timeline. Some factors that may influence this timeline include the need for staff in-service training, and pace of student skill attainment.

**Indirect Service**
Instruction and/or services are determined by identified student needs, goals and objectives, and should be seamlessly integrated within the school day. All team members must work together collaboratively on an ongoing basis, which can be challenging when a team member is not in that school setting every day. Given the assumption that many P/HD teachers have an itinerant role and serve many schools, it is important to maintain professional connections and utilize avenues of communication. In addition, many districts require staff to maintain documentation of services, contact logs, email, and phone calls. Sustaining open communication and providing documentation of services is a vital and necessary way of staying connected to the students, families and educational teams.

**Evidence-Based Practices**
Evidence-based practices incorporate what is known through current research, and is complemented by the experience and knowledge of the practitioner, with the goal of achieving desired outcomes for the student within the educational program. Using evidence-based practices requires the educator to stay current with research in the field, and can include any of the following: Active participation in graduate level studies; reading/subscribing to professional journals; participating in study groups and/or discussions with other professionals in the field; and membership in professional organizations. Evidence-based practices also suggest that educators continuously evaluate their current practices with regard to use of curriculum, evaluation tools, learning and instruction.

**Writing the IEP: Goals and Objectives**
IEP goals and objectives must be based on the identified educational needs that were linked to the medical diagnosis in the evaluation report. Areas of need often extend beyond the academic domain and are critical to the development of independence in the educational environment. Some examples may include:

- Organization and planning
- Independent work completion
- Self-advocacy skills
- Fine and gross motor skills
- Disability awareness
- Problem solving and reasoning
- Independent use of assistive technology and adaptive equipment
Some students have conditions that are progressive in nature (e.g., Duchenne Muscular Dystrophy). This may result in difficulty in writing goals and objectives that reflect an increase in skills or independence with motor tasks. Rather, the goals and objectives could focus on the student’s ability to understand the implications of his/her diagnosis, direct others to meet his needs, and identify and use available accommodations and resources. In such situations, it may be helpful for the team to consider the implications of the prognosis and to be realistic about outcomes. The goals and objectives may need to be revised if the student’s medical condition changes significantly over the course of the school year.

**Accommodations and Modifications**

For students qualifying under the PI category, accommodations and modifications are a critical component of the IEP, and require careful team consideration and advisement from the P/HD teacher. A clear understanding of the student’s needs as related to the physical disability is a necessary first step.

The Individuals with Disabilities Education Act has been reauthorized several times since 1975, most recently in 2004. IDEA 2004 uses the term "accommodations" to describe changes to the ways students learn and are tested. Other similar definitions suggest that an accommodation is a change that helps a student overcome or work around challenges imposed by the disability.

Specifically, *accommodations* include:

- Supplementary aids and services to be provided to the student
- Classroom and testing accommodations
- Supports for school personnel to address the needs of the student with disabilities
- Individual accommodations in the administration of state or direct assessments

Some broad examples of *accommodations*:

- Emergency evacuation plans
- Individualized Health Plan
- Modified school schedule
- Access to adaptive equipment and assistive technology
- Testing accommodations
- Extended assignment due dates
- Alternate response formats
- Additional adult support
- Alternate bus transport
- Alternate instructional setting (home, hospital)
**Modifications** are often defined as a change in what is taught to or expected from the student. Adapting or modifying the content, methodology, and/or delivery of instruction is an essential component of special education and should be carefully considered by the educational team before implementation, particularly if the student’s educational needs are complex. For this reason, P/HD teachers receive specialized training in how best to customize curriculum, materials and/or instruction, allowing them to meet the unique needs of the student with a physical impairment.

Some broad examples of *modifications* may include:

- Modified curriculum content
- Modified content for classroom assignments and tests
- Modified grading
- Modified course requirements
- Modified district and state testing requirements

**Statewide Assessment for Students with Disabilities**

The federal Individuals with Disabilities Education Act (IDEA 2004) and No Child Left Behind Act (NCLB) mandate that all Minnesota students, including students with disabilities, participate in statewide assessments in the areas of reading and mathematics using the Minnesota Comprehensive Assessments (MCA-II) or an appropriate alternate assessment. An alternate assessment is designed exclusively for use with students who receive special education services and is a way for states to measure the achievement of these students based on alternate achievement standards. For more information on statewide testing and accommodations, refer to *The Minnesota Manual of Accommodations for Students with Disabilities in Instruction and Assessment*, found on the MN Department of Education and the National Center on Educational Outcomes websites. This manual is a helpful resource for IEP teams when determining the need for, and relationship between, accommodations used in instruction and in assessment.

Part VIII

Key Services & Supports
In the Educational Setting
Birth to Age 21
Key Services & Supports for Students with Physical Impairments

Educational teams are made up of many critical service providers who, through strong collaborative efforts, create meaningful and high quality educational programming for students with physical impairments. Because of the unique and sometimes complex physical, health and learning needs of these students, educational teams can sometimes be quite large and intimidating for families. Such a situation often requires a skilled and knowledgeable case manager with strong interpersonal communication and group facilitation skills.

All members are valued team participants, and expected to bring their own professional expertise and knowledge to the table. However, some professionals play critical roles when providing services to students with physical impairments.

Related Services

Related services are designed to support the student’s special education program, and includes transportation and such developmental, corrective, and other supportive services as are required to assist a child with a disability to benefit from special education, including:

- speech-language pathology and audiology services
- interpreting services
- psychological services
- physical and occupational therapy
- recreation, including therapeutic recreation
- early identification and assessment of disabilities in children
- counseling services, including rehabilitation counseling
- orientation and mobility services
- medical services for diagnostic or evaluation purposes
- school health services and school nurse services
- social work services in schools
- parent counseling and training
In addition, there may be other related services that schools routinely make available under the umbrella of related services. The IEP team decides which related services a child needs and documents these services in the child’s IEP.

**Occupational Therapy (OT) and Physical Therapy (PT)**

Occupational therapy is defined as a related service provided by a qualified occupational therapist, and includes improving, developing or restoring functions impaired or lost through illness, injury, or deprivation; improving ability to perform tasks for independent functioning if functions are impaired or lost; preventing, through early intervention, initial or further impairment or loss of function. (Federal Definition 34 C.F.R. 300.24)

Physical therapy is defined as services provided by a qualified physical therapist. (Federal Definition 34 C.F.R. 300.24)

In order for a student to receive OT or PT services, he/she must be identified as a student who has qualified for special education services under one of the primary special education categories; demonstrate a need for special education instruction; and demonstrate a need for supplemental/complimentary support services. These services must relate to primary educational goals; and the team must determine that, without the expertise of the therapist as a team member, a student could not achieve the goals and objectives documented on the IEP.

**Developmental Adapted Physical Education (DAPE)**

DAPE is defined in Minnesota Rule as “specially designed physical education instruction and services for pupils with disabilities who have a substantial delay or disorder in physical development.” (M.R. 3525.1352, subp.2) DAPE is not a related service. This Rule states that the student must meet specified criteria in order to qualify for DAPE services. In addition, the pupil must also meet the criteria for a specific disability category or early childhood special education. For many students, this disability category is often Physically Impaired (PI).

Occasionally, a student may have DAPE listed as the only direct service on their IEP, a result of the student demonstrating no other educational needs other than in the physical education class setting. However, the student must also receive services from the teacher who is licensed in the qualifying disability category. (In the case of Physically Impaired, this would be the P/HD teacher.) As defined in MN Rule 3525.2350, Multi disability Team Teaching Models, the P/HD teacher must then participate in the evaluation and IEP planning process. In such cases, the P/HD teacher will often conduct at least one of the classroom observations in the physical education class, and determine if educational needs are sufficient enough to warrant qualification and meet criteria under the PI category.
In addition to involvement in the evaluation and IEP planning process, the P/HD teacher must, at a minimum, also provide indirect/consultation services to the general or special education teacher providing instruction to the student.

**School Health Services**
The school nurse plays an important role on the team when serving students with physical impairments. The school nurse may often serve as a member of the child study team, and assist with the special education evaluation by providing a health record review, summarizing sensory and health needs, including hearing and vision screening results. The school nurse may be asked to serve as a liaison with the family’s physician or clinic nurse, and may assist the team in obtaining medical documentation of the diagnosis, as well as related information and resources. The school nurse may also assist the team in ongoing discussions that address physical fatigue and endurance issues, school attendance, health care procedures, nutrition, sleep patterns, medications and side effects, return-to-school protocols following hospitalization, etc. (See ‘Referral and School Re-Entry’ section in this manual.)

‘School nurses determine plans and treatments specific to students’ health, development and capabilities, and can include medication administration, nutrition, rest, communication and mental health interventions. More and more the care involves medical supports such as tracheostomies, ventilators, catheters, colostomies, limb braces, wheel chairs, respiratory care including oxygen, feeding tubes, insulin pumps and an increasing list of new devices. The school nurse determines if and when specific nursing tasks are delegated and to whom, and provides training and supervision.’ (Taken from: *An Overview: Minnesota School Health Services and School Nursing Practice*, MN Department of Education, Safe and Healthy Learners, 2009.)

As a member of the team, the school nurse may be asked to attend IEP meetings and assist in identifying health-related accommodations and services that may be needed during the school day, and should be listed on the IFSP or IEP service page as a service provider.

The school nurse often takes a lead role in creating *individualized healthcare plans (IHP)* for students with physical impairments who have a related health condition. Some conditions may require additional documentation and procedural information than what is typically found in an IEP. *An emergency care plan (ECP)* may be developed by the school nurse and the educational team if the student has a related health condition that may result in a medical emergency while at school. The school nurse may also assist the team when developing an emergency evacuation plan (EEP) if the health condition requires special consideration during an emergency evacuation on school grounds.
Additionally, the school nurse often assists in obtaining resources, as needed, for inclusion of students with physical/health conditions in the classroom or school setting, including space and privacy for specialized healthcare procedures, special supplies, or equipment. School nurses also work with other team members to provide educational opportunities that help students learn more about their condition, develop self-care skills, and become more independent; and help with in-service programs for teachers, staff, parents, and students.

For more information on school health services, the role of the school nurse, and other related topics, please refer to the MN Department of Education Other Health Disabilities Manual, revised 2011.

**Paraprofessional Services**

A paraprofessional is defined in Minnesota Administrative Rules as “a district employee who is primarily engaged in direct interaction with one or more pupils for instructional activities, physical or behavior management, or other purposes under the direction of a regular education or special education teacher or related services provider.” (3525.0210, Subp. 33) When working with students with physical impairments, the role of the paraprofessional may vary and are often dependent upon the needs of the student and program design. Some important considerations for paraprofessionals who work with students with physical impairments include:

- Reinforce the use of appropriate social skills. Model methods for making appropriate choices and making and maintaining friendships.
- Set similar expectations and standards of effort for the students you work with as for other students their age.
- Let students know that you have high expectations for them. With consistent encouragement from others, students will have high expectations for themselves.
- Continually ask yourself, “Am I as far away as I can safely be in this case?” and “How much of this task can this student do without my direct assistance?”
- Encourage students to take cues from the person in charge, whether a teacher, a job supervisor, or a peer group leader.
- Although it is quicker, easier, and less frustrating for the paraprofessional to do a task, it is important to assist students in learning how to do their own work. We must remember that it is their work.
- Encourage students to assist each other when help is needed.
- Relate to all students as equals.
- Give students choices instead of telling them what to do or making decisions for them. Allow them time to think. Teach them how to think.

*Adapted from the Paralink*

For more resources in the area of paraprofessional support, refer to the MN Department of Education website.
Part IX

Key Services & Supports
in the Community Setting
Birth to Age 21
Overview
There are a number of community support services which may be available to students with disabilities of all ages, depending upon specific agency or program qualifications. A few of these programs and services are described below.

CADI Waiver
Community Alternatives for Disabled Individuals (CADI) program is provided through county and state funding, and intended to promote community living and independence by providing appropriate health care and support services based on individual needs. CADI provides home and community based services necessary as an alternative to institutionalization that promote the optimal health, independence, safety and integration of a person who would otherwise require the level of care provided in a nursing facility.

Eligibility requirements include the following:

- Be under age 65
- Be certified disabled by Social Security for the State Medical Review Team (SMRT) process
- Be eligible for Medical Assistance (MA)
- Require the level of care provided in a nursing facility
- Have had a Preadmission Screening (PAS)
- Choose community care
- Have an individual care plan that assures your health and safety; and
- The cost to MA for community care cannot exceed the cost to MA for nursing home care

If determined eligible to receive CADI services, you can receive the full range of services covered by MA. These services include medically necessary hospital care, physician care, nursing services, prescription drugs, medical supplies and equipment, dental services, therapies, and medical transportation. Special services that are necessary to prevent nursing home placement may be available under CADI and include case management, adaptations to home vehicle, or equipment, homemaker services respite care, adult day care, family counseling and training, foster care, independent living skills, extended home health services, assisted living, residential care services, home delivered meals, prevocational services, and supported employment services.
In addition to the CADI Waiver, there are other waivers available that are specific to the client’s condition or type of need. To learn more about waivers, contact your county resource center for more information.

**Minnesota Health Care Programs**

The Minnesota Department of Human Services ensures basic health care coverage for low-income Minnesotans through four major publicly subsidized health care assistance programs. Minnesota offers three primary health care programs that *may help families pay for medical costs*.

- Medical Assistance is Minnesota’s Medicaid program for low-income families.
- MinnesotaCare is a subsidized health insurance program for Minnesota families who do not have access to affordable health care coverage.
- General Assistance Medical Care provides coverage for parents of children who are between the ages of 18 and 21.

In addition, Minnesota offers the following health care program options *to cover the health care needs of children with disabilities*.

- TEFRA allows some children with disabilities who live with their families to be eligible for Medical Assistance without counting parent’s income.
- Home and Community Based Waiver programs allow some children with disabilities who live with their families to be eligible for Medical Assistance without counting the parent’s income.
- Medical Assistance for Employed Persons with Disabilities allows working children with disabilities who are at least 16 to qualify for Medical Assistance under a higher income limit.

To apply, a Minnesota Health Care Programs application must be completed, which can be found on the MN Department of Human Services website (or contact your local county resource center).
Personal Care Assistant (PCA) Services

Personal care assistants provide services to individuals who need help with day-to-day activities to allow them to be more independent in their own home. A PCA is trained to help persons with a variety of basic daily routines. Depending upon their circumstances, children and/or youth with disabilities and their families may benefit from this service.

To be eligible for the personal care assistance program, a person must meet all these criteria:

- Be eligible to receive Medical Assistance (MA) or MinnesotaCare Expanded (pregnant women and children)
- Require services that are medically necessary and ordered by a physician
- Be able to make decisions about their own care, or delegate someone who can make decisions for them, i.e., parent or guardian.

Families should contact their local county resource center and request an initial assessment for PCA services. A nurse will contact them to arrange the initial assessment.

(This information was taken from the document entitled, Transition Guide for Students with Physical Impairments, created in 2010 by the Regions 5 & 7 Physical/Health Disabilities Network, and available as a downloadable resource on the MN Low Incidence Projects PI Resources webpage.)
Part X

Serving the Transition-Aged Student
Overview
Minnesota Rule 3525.2900 (Subp. 4) defines transition planning as the process that is initiated by grade nine or age 14 (whichever comes first) that provides the framework for planning the transition from secondary school services to postsecondary education and training, employment, and community living. The IEP plan addresses the student's needs for this transition, including an evaluation of secondary transition needs and appropriate services to meet the pupil's transition needs.

Providing assistance to students with physical impairments and their families offers a unique set of questions and issues to consider. Students preparing for transition into adulthood need to address many questions related to financial support, post-secondary training and learning, employment, residential options, transportation and social-recreational and leisure opportunities.

Evaluation
To appropriately evaluate and plan for a student's secondary transition, additional IEP team members or invited guests may be necessary and could include vocational education staff members and other community agency representatives. When addressing the transition needs of a student with a physical impairment, such agency representatives may include a county social worker, vocational rehabilitation services counselor, community rehabilitation /therapy staff, or vocational or residence program staff. Discussion will often focus on additional evaluation needs, such as:

- Accommodations in vocational, community, or college settings
- Driver's assessment and training
- Qualifying for and setting up PCA (personal care attendant) services
- Applying for community support services, such as:
  - CADI-waiver services
  - MN Health Care programs
  - Supplemental Security Income (SSI)
  - Subsidized housing

Identifying additional community and online resources are also an important part of the transition discussion, such as the MN Centers for Independent Living (MCIL), Courage Center, MN Disability Law Center, eFolio, Project 3C, etc.
Secondary transition evaluation results must be documented as part of an evaluation report. Current transition needs and goals, as well as instructional and related services identified by the evaluation team must be considered for inclusion in the IEP, and documented accordingly.

Some of these services and supports are explored in more detail on the following pages.

**College Disability Services**

Section 504 of the Rehabilitation Act of 1973 and Title III of the Americans with Disabilities Act of 1990 (ADA) state that: *No otherwise qualified individual...shall, solely by reason of his or her disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.* Because of this, each post-secondary institution which receives federal funding has at least one designated staff member who helps with modifications and accommodations for students with disabilities.

Modifications and accommodations for students with disabilities generally include, but are not limited to:

- Removal of architectural barriers
- Provision of services such as readers for students with blindness, visual impairments, or learning disabilities; scribes for students with orthopedic impairments; and note takers for students with hearing impairments, learning disabilities, or orthopedic impairments
- Allowing extra time to complete exams
- Taking exams in a separate, quiet room
- Permitting exams to be individually proctored, read orally, dictated, or typed
- Permitting the use of computer software programs or other assistive technological devices to assist in test taking and study skills

Not all colleges and universities use the term *Disability Services*, but all institutions of higher education which receive federal funding are required to offer supports for students with disabilities.

**Supplemental Security Income (SSI)**

Supplemental Security Income (SSI) is coordinated through the Social Security Administration, and pays monthly checks to the elderly, the blind, and people with disabilities who meet income guidelines. SSI recipients often qualify for food stamps and Medicaid as well.

A disability is defined as having a physical or mental impairment that is expected to last at least a year or result in long term care. Children, as well as adults, can qualify for and receive benefits as a result of a disability if they meet criteria.
Financial support may vary, depending upon the state in which you live, family income, net value, etc. To get benefits from the Social Security Administration, you must live in the United States as a United States citizen or other legal resident.

Call 1-800-772-1213 to set up an appointment with a Social Security representative. People who are deaf or hearing impaired may call the toll-free “TTY” number: 1-800-325-0778. Local offices are also available in your area. www.ssa.gov  www.socialsecurity.gov

**Vocational Rehabilitation Services**

**MN Department of Employment & Economic Development**

The Division of Vocational Rehabilitation (DVR) assists individuals with physical or mental disabilities in becoming employable. Services include diagnostic and evaluation services to help establish eligibility, guidance, counseling, education and training.

Prior to a student’s senior year, contact the vocational rehabilitation (VR) counselor that works with the student’s district. You may be able to access vocational rehabilitation services if the disability makes it difficult to develop work skills, and find/retain a job. In order to qualify for services, the DVR counselor will review reports from the student’s physician, school, or other outside agencies.

VRS would like to serve all people who have a disability, but may be limited, due to staffing and budget considerations. Services are determined on a case by case basis, and are impacted by Federal funding. People who have serious limitations in specified areas will be served first. This is called “Priority of Services.” There is no charge for counseling or job placement services. VRS can also pay for some services provided by other agencies. Service fees are based on a sliding scale.

**Drivers’ Assessment & Training**

A drivers’ assessment/evaluation is designed to measure a person’s ability to safely operate a motor vehicle. If a student has a disability and has not yet learned to drive, the assessment/evaluation might be their first step in determining their potential to drive a motor vehicle safely and independently. The evaluation will involve measuring visual, cognitive and physical skills, as well as the need for adaptive equipment, and will include a behind-the-wheel assessment. After completing a drivers’ evaluation, recommendations will be given that may include drivers’ training. Individual driver’s training is based on the individual’s needs and abilities in safely and independently operating a motor vehicle.
Individuals may access Drivers’ Assessment/Evaluation and Training services through a variety of funding options, including private insurance and self-pay. Individuals who qualify for services through Vocational Rehabilitation may also access funds through this agency. For more information on qualified evaluation programs, contact the local Dept. of Motor Vehicles agency.

* * *

Much of this information was taken from the document entitled, *Transition Guide for Students with Physical Impairments*, created in 2010 by the Regions 5 & 7 Physical/Health Disabilities Network. For more information on these and other resources, refer to this document, which is available as a downloadable resource on the MN Low Incidence Projects PI Resources webpage.
Part XI

Student Safety
**Emergency Evacuation Procedures**

The Americans with Disabilities Act and the Rehabilitation Act require school districts to make reasonable accommodations for students with disabilities—which must include making plans for a safe evacuation from the school setting. State law and local safety codes set specific requirements. The Minnesota Department of Public Safety-State Fire Marshal Division Statement of Policy notes acceptable alternate strategies to complete the evacuation of persons with mobility impairments from multi-story buildings. *Only when these guidelines have been met will the State Fire Marshal Division allow people to remain in a building during a drill or emergency situation.*

The IEP team must consider, on a case-by-case and situation-specific basis, whether to develop an individual evacuation plan for each student with a disability, such as a fire or natural gas emergency, or a lock-down situation. The emergency evacuation plan must coordinate with the overall building/district evacuation plan. Special consideration must be given to multi-story buildings. In order to have fire safe/rescue rooms established within buildings, the school district must work with the local fire marshal.

During each drill, it is important that students, staff and other building occupants practice what they will do in an actual emergency. As stated in the rationale of the Minnesota Department of Public Safety, Statement of Policy, “some schools have separate procedures for drills and actual fires to prevent injuries. This can lead to confusion and, in reality, increase the risk of injury to building occupants during an actual emergency. There is a need to provide alternate strategies to complete building evacuation to minimize this risk of injury”. If an IEP team determines that a fire safe room / rescue room is the best option for a student, the team must work closely with the school district and the area fire department to ensure safety procedures are properly followed.

**Steps to Consider**

After determining that a student needs a plan and reviewing your district plan, the team needs to meet to determine the following:

1. **Who**: Responsible staff for escorting the student out of the building and/or down stairs

2. **When**: Time frames/class schedules

3. **Where**: Class location, exits, etc. and the destination for the student
4. **What:** Special supplies (i.e. blanket, assistive technology device, whistle, walkie-talkie), special medical attention, and other considerations

5. **How:** Possible solutions:
   - Student follows evacuation plan procedure with minimal assistance/cues
   - Guidance/support by an adult (use of transfer belt for extra support)
   - Carries: two person, fireman’s carry, cradle lift, etc.
   - Tuk-N-Kari /Sling
   - Evac Chair
   - Stair Trak
   - Rescue room /Fire Safe room

6. **Additional Considerations:**
   - Map of building
   - Distribution may include: Administration, health services, fire department, IEP case manager/team members, classroom staff, substitute folders

7. **Approval of Plan:** In addition to team members, parents may participate in creating and reviewing the plan, and giving input. If appropriate, parents or staff should review the plan with the student.

**Lifting Techniques** (Note: Verify techniques with a physical therapist who works with the student and/or provides support to the school staff.)

**Cradle Lift or One Person Carry**

1. Lock wheelchair brakes, undo belts and other restraints.
2. Stand beside the student with your feet apart.
3. Bend at your hips and knees, keeping your back straight.
4. Place one arm around the student's opposite arm.
5. Place another arm under student's thighs.
6. Lift student by straightening your legs.
7. Hug student close to your body.
8. Turn by moving your feet. DO NOT TWIST!
9. Lower student to the ground/surface by bending your hips and knees, keeping your back straight.
Two Person Lift from the Wheelchair

1. Lock wheelchair brakes, undo belts and other restraints.
2. Place the student's arms over his/her chest.
3. One person stands behind, or if not possible, beside the wheelchair and puts his/her arms under the student's arms and grasps the student's forearms (lifter crossing his/her arms if possible, i.e. cross chest hold as above). If unable to grasp the student's forearms, lifter should grasp his/her own wrist.
4. The other assistant stands in front of the student and lowers self by bending hips and knees.
5. The person in front grasps the student under the knees with both arms.
6. The person lifting the upper body counts: “1-2-3-lift”.
7. On "lift", the student is lifted out of the wheelchair.
8. Lower student to the ground/surface by bending your hips and knees, keeping your back straight while counting “1-2-3-down”.
EMERGENCY EVACUATION PLAN TEMPLATE

Student Name: _____________________________________________ Grade: ____

School Year: ______________

Case Manager: ______________

Classroom Teacher/Room Number: ____________________________

Student Description (disability/condition, equipment needs, etc.): _______

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

Physical/Safety Issues: __________________________________________

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

Method of Communication: _________________________________________

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
Procedures:

- In the event of a fire drill/emergency:

- In the event of a severe weather drill/emergency:

- In the event of a tornado drill/emergency:

- In the event of a lock-down drill/emergency:

Location and Staff assigned:

Special Considerations:

Notes:

- This document to be filed with current year IEP and/or IHP.
- Student should be made aware of plan, and kept informed of updates.
- Copies of this document should be provided to school administration, all IEP team members (including parents/guardians), and school health services.
TRANSPORTING STUDENTS WITH PHYSICAL IMPAIRMENTS

Taken from: A Provider’s Guide to Transporting Students with Disabilities; Published by the MN Department of Education (Formerly the MN Department of Children, Families & Learning at the time of publication)

Driver Training:
What additional training is required for a bus driver who transports students with disabilities on a special transportation route?

One of the competencies required of bus drivers in Minnesota statute is an understanding of student behavior, including issues relating to students with disabilities. In addition, Minnesota law (M.R. 7470.1700, Subp. 3) requires that each driver:

1) Be instructed in basic first aid procedures for the pupils under their care

2) Within one month after the effective date of assignment, participate in a program of in-service training on the proper methods of dealing with the specific needs and problems of pupils with disabilities

3) Assist pupils with disabilities on and off the bus when necessary for their safe ingress and egress from the bus

4) Ensure that protective safety devices, as required in M.R. 7470.1600, Subp. 6, are in use and fastened properly

Furthermore, it is recommended that a driver of any route that includes students with disabilities receive appropriate training as noted in the Department of Public Safety Rules.

Wheelchair Orientation:
What are the requirements for a forward-facing or side-facing wheelchair orientation on a school bus?

Types A, B, C and D school buses manufactured after January 1, 1995, must have wheelchair securement devices in a forward-facing orientation. Types A, B, C and D school buses manufactured before January 1, 1995 may have either a forward- or side-facing wheelchair orientation. Type III school buses, no matter when they were manufactured, may have either forward- or side-facing wheelchair securement devices. (See M.S. 169.4504.)
Wheelchair Tie-Downs:
Are there requirements for how a wheelchair should be securely fastened inside the bus?

Whether side-facing or forward-facing, all wheelchairs must be securely fastened in a fixed position to prevent movement. This securement system must utilize a four-point tie-down design. In addition, each wheelchair location must have an occupant restraint system. This system must be attached to the bus body either directly or in combination with the wheelchair securement system. (See M.S. 169.4504, subd. 3-4.)

The information provided in this document does not constitute legal advice. School districts should seek legal counsel as necessary.
Part XII

Administrative Considerations:
Supporting the P/HD Teacher
**Administrative Considerations:**

### Supporting the P/HD Teacher

**Recruitment and Retention**

Due to the nature of low incidence populations of students, there may be occasional shortages of Physical/Health Disabilities teachers around the state, particularly in the rural regions. Administrators may want to encourage special education teachers already employed in their districts to pursue a licensure in Physical Health Disabilities. Teachers who demonstrate both the professional interest and traits required of itinerant teachers be strong candidates for an itinerant P/HD teacher position. Such traits would include effective communicative, organizational and time management skills, and an ability to work effectively with others.

Potential candidates will require a concise job description that outlines the unique responsibilities of the position, which should include qualifications, areas of responsibility (including workload and itinerant school/district assignment), professional expectations, and a supervisory hierarchy. In addition, candidates should be made aware of performance review schedules, district expectations and policies, and their responsibilities under state and federal law. The framework for traditional performance reviews may need to be revised to reflect the unique nature of an itinerant low incidence specialist.

There are many factors contributing to the retention of P/HD teachers in local school districts. Some of these factors include: The ability to provide adequate mentoring or coaching from a similarly licensed professional; good working conditions; manageable workload (in terms of student numbers and geographical assignments); opportunities for professional growth through attendance at workshops, conferences, and affiliated network meetings; flexible scheduling; competitive salaries and benefits; and opportunities for professional collaboration.

**P/HD Tuition Support Program**

A recent initiative to offer tuition support to graduate level special education teachers interested in pursuing P/HD licensure has significantly improved the availability of licensed candidates. The P/HD Tuition Support Program is coordinated by the Minnesota Low Incidence Projects, and funded through a grant awarded by the Minnesota Department of Education. Interested applicants are required to complete an application, and complete required courses through sanctioned university graduate programs.

For more information on the P/HD Tuition Support Application process, visit the MN Low Incidence Projects PI Resources webpage, or contact the Statewide PI Specialist.
Practicum Teacher/Cooperating Teacher Experience

There is a long held belief that it is the professional responsibility of teachers to contribute and support the education of practicum (student) teachers whenever possible, thereby continuing to strengthen their professional community. It is the hope that this philosophy is supported by every school administration.

The practicum student’s college is responsible for establishing a contract or written agreement that outlines the responsibilities of each party, i.e., liability coverage, standards of performance, expected outcomes and competencies, etc. Supervision of practicum teachers offers advantages for both the tenured teacher and the school district through the sharing of current information and resources, earned CEUs, and opportunities to dialogue with colleagues in higher education.

Factors influencing the choice of a cooperating teacher (who provides onsite supervision) should include years of teaching experience, an interest in participating, sufficient time to serve as a coach, and a commitment to maintaining current evidence-based practice. A cooperating teacher should follow his/her district policy with regard to notifying parents/guardians about the involvement of a practicum teacher in their child’s educational program.

Professional Coaching for the P/HD Teacher

The loss of qualified special education teachers is a significant barrier to ensuring that the federal mandate of a free, appropriate public education is provided to all of Minnesota’s students identified for special education. Teachers are particularly vulnerable to attrition early in their careers or when making major changes in their assignments.

Research suggests that participation in well-designed and well-implemented professional coaching programs can provide educators with the kinds of information, support, and connection to professional communities that may strengthen the start or continuation of their careers. In an effort to strengthen Minnesota’s support for educators teaching in the Physical/Health Disabilities field (as well as other low incidence areas), statewide professional mentoring or coaching programs for special educators new to these areas began in the 2004-2005 school year, and continue to the present day.

Many schools and districts throughout the state currently run successful coaching programs, providing educators with assistance of a generalized nature. Practitioners in low incidence disability areas such as Physical/Health Disabilities can benefit from such opportunities. However, they also have very specific and unique needs that require the assistance of educators who are experts in the same low incidence field.
Some unique professional needs may include: acquiring highly specialized knowledge and skills to serve their students; locating disability-specific resources and equipment; and adjusting to the isolation of working in a low incidence field, particularly in the rural areas of the state. It is for these types of needs that Minnesota’s coaching programs for special educators new to low incidence disability areas were designed.

**Continuing Education**

Supporting staff development opportunities is a shared responsibility of both the teacher and the school administration staff. Given the consultative role of the P/HD teacher, such opportunities increase the amount of shared knowledge tenfold in a district, enabling many staff to benefit from the training. As with other Minnesota educators, P/HD teachers are required to complete 125 clock hours over a 5 year period, and should work with their administrator in satisfying this requirement.

P/HD teachers are strongly recommended to actively participate in Statewide P/HD Network meetings, which meet 3 times during the school year; two of those meetings are day-long. Network members may either attend on site (typically held in Minneapolis-St. Paul metro area), or virtually via ITV. Clock hours are available for all network meetings.

**Workload Considerations**

Because of numerous variables, determining consistent and fair caseload or ‘workload’ numbers for itinerant low incidence special educators has long been a challenging task for administrators. There are many job activities that make up a typical itinerant P/HD teacher’s day, including many of the following:

- Indirect services: Consulting with other team members; conducting in-services
- Direct services (less frequent): working with a student on a specific skill
- Student evaluations: evaluating student, meeting with other team members, writing report, attending evaluation share meeting
- Meetings: IEP, team, and local school meetings
- Travel between schools
- Set-up & trial use of technology
- Modifying curriculum, materials, and equipment
- Ongoing communication: phone calls, email
- Documentation: Student logs, IEP progress, service logs
- Program planning, schedule development
- Professional staff development activities
- Investigating/updating resources and agency information
To assist in the task of determining what a fair and consistent caseload might be, the Minnesota Department of Education created a professional resource in 2001 entitled, ‘Workload considerations for Effective Special Education’, setting forth recommendations intended to assist administrators, teachers, and parents to examine special education teacher workload through a conceptual framework, with the intention of ensuring that teachers can address the special instructional needs of students with disabilities, and at the same time also meeting the unique requirements of their positions. The model is intended to be a framework that can be adapted to the changing tasks, responsibilities, and requirements of special education teachers, including itinerant teachers (Chapter 3). Through comparisons across settings, buildings, and districts, the hope is that administrators are better able to analyze the relative workloads of staff and respond proactively to the challenge of planning for teaching students with disabilities.

Some administrators have chosen other methods of establishing workloads, such as comparing workloads in similar settings and geographical locations; creating customized formulas and ratios, or asking P/HD teachers to accommodate current needs, whatever they may be.

Whatever the method of determining workload, it is clear that overly large itinerant workloads can have a negative impact on the quality of services to students and their families, and ultimately may have a detrimental effect on the itinerant educator’s job satisfaction and retention in the field.

**Itinerant Job Description**

The Workload Manual also includes a Sample Job Description for Itinerant Special Education Teachers; administrators may choose to use this sample as a template and further customize the form to meet their local district needs. (Note: This sample job description can also be found in the appendices of this manual.)

**Instructional/Office Space, Equipment & Supplies**

When appropriate, the itinerant P/HD teacher should be provided with instructional space to work with or evaluate students, as well as office space to complete such work-related tasks as writing reports, meeting with colleagues, making phone calls, sending email, modifying materials, customizing curriculum, etc. Since the P/HD teacher is often at multiple sites on any given day, building administrators should work with their staff to designate adequate space for itinerant educators. All Itinerant staff should have a primary ‘home base’ and be provided with their own desk, computer/laptop, Internet access, phone, locked file drawer(s), equipment storage, and access to clerical support and professional resources.
Professional Supports & Resources

P/HD teachers are strongly encouraged to participate in and/or utilize available professional staff development opportunities and/or resources, such as:

- **Regional P/HD Network:** Contact your regional low incidence facilitator (RLIF) to learn more.
- **Statewide P/HD Network:** Contact the Statewide Specialist to join and/or learn more.
- **Annual Charting the Cs/Cross-Categorical Conference:** An annual statewide conference for low incidence special educators. Registration information is posted annually on the Statewide P/HD List Serve.
- **Statewide P/HD List Serve:** For information on subscribing, visit the MN Low Incidence Projects PI Resources webpage, or contact the Statewide PI Specialist.
- **MN Low Incidence Projects Website:** A wide array of guidelines, manuals, resources and event postings for P/HD teachers. [www.mnlowincidenceprojects.org](http://www.mnlowincidenceprojects.org)

- **Statewide ‘Judy Wolff’ PI Library:** A variety of professional journals, DVDs, books, technology, and other resources available at no cost to P/HD teachers and other low incidence educators; users are required to register before checking out materials.
Part XIII

Frequently Asked Questions (FAQ)
EVALUATION & QUALIFICATION

1. **How does the P/HD teacher become involved in the identification of a student with a physical impairment?**

   The P/HD teacher should be involved in the development of the Evaluation Determination Plan when a student has a documented medical diagnosis of a physical impairment and there are possible related educational concerns. A teacher licensed in the disability area being considered must be included as a member of the evaluation team. The P/HD teacher’s role during the evaluation is to determine, using the criteria for Physically Impaired, whether the student is in need of special education services; and to participate in the development of the IEP. An evaluation of a student who has a physical impairment addresses the same areas that a typical evaluation does, and follows the same due process procedures as all other areas of special education. The State Criteria for Physically Impaired states that a P/HD teacher must complete at least one of the evaluation observations. Additionally, Minnesota Rule 3525.2350, Subp.3 (Multi-disability Team Teaching Models) states: ‘The team member licensed in a pupil’s disability shall be responsible for conducting the pupil’s evaluation and participating at team meetings when an IEP is developed, reviewed, or revised.’

2. **If there is documentation of a medical diagnosis resulting in a physical impairment, does this automatically mean that a student needs special education services and would meet the special education criteria under the PI category?**

   No. A student with a medical diagnosis that results in a physical impairment does not always need special education services. The documented medical diagnosis is only one part of the Physically Impaired criteria. The student must also meet one of the components under Part B of the criteria in order to qualify for special education services. There are some students with a medically diagnosed physical impairment who utilize accommodations, are academically successful in the school setting, and do not require special education services. These students may be most appropriately served under a Section 504 Rehabilitation Plan, which documents the accommodations necessary for successful participation in the general education setting.
3. The PI Criteria describes the inability to manage or complete motoric portions of classroom tasks. Could the gymnasium be considered a classroom?

Yes. Physical education is an academic area with specific curriculum, and the gymnasium is the classroom where the instruction takes place, just as other curriculum such as reading or math is delivered in the traditional classroom. For younger or home schooled students, their classroom could be their home or community settings.

4. How is Physically Impaired (PI) different from Other Health Disabilities (OHD)?

While both criteria require a medical diagnosis, the student with a physical impairment has a diagnosed chronic physical impairment, congenital or acquired, that adversely effects physical or academic functioning. The student with a health disability has a chronic or acute health disability. A physical impairment is different from chronic health impairment, although many students with a physical impairment will have secondary health issues related to their medical condition. If the health disability is related to or is caused by the physical disability and the student meets PI criteria, the team should consider PI as the primary category. However, many situations where both physical and health conditions exist can be complex and the decision should be left to the educational team.

Another significant difference between the PI and OHD criteria is the requirement of including a P/HD teacher on the team that is serving a student with a physical impairment. There is no required teacher licensure (beyond special education teacher licensure) for OHD; however, MN Rule states that the special educator must have ‘knowledge and expertise’ in working with students with other health disabilities. There are certain situations where it may be appropriate for the P/HD teacher to be involved with a student who meets OHD criteria due to a chronic health condition that impacts learning (e.g., cancer, rheumatoid arthritis, cystic fibrosis, etc.), as P/HD teachers have expertise and training that may contribute to the student’s educational programming.

5. What about medical diagnoses that fall outside the spectrum of more traditional conditions which are typically associated with having a physical impairment?

Because of rapid changes in the medical field and related technology over the past few years, the medical diagnostic process has become more complex, with ever-changing terminology.
If the medical diagnosis appears to be the primary cause of a physical or motor impairment, then the educational team could consider the diagnosis for qualification purposes. Some examples are hypotonia, ataxia, motor apraxia, developmental coordination disorder, static encephalopathy, etc.

Some conditions are so broadly defined that the team may want to have further discussions with the family and medical provider. For example, hypotonia is a medical term indicating the presence of low muscle tone, and may be an accompanying descriptor of cerebral palsy. But it can also be associated with a number of other medical diagnoses or syndromes, and more medical information may be needed from the student’s family for the evaluation team to determine if the student meets the criteria for physically impaired and/or other special education categories. If no other diagnosis is available that clearly defines the medical condition, consensus from the professional P/HD states that hypotonia can be considered a viable medical diagnosis of a physical impairment.

Some conditions are more of a medical descriptor than an actual chronic medical diagnosis, such as prematurity or preterm birth, and Very Low Birth Weight (VLBW), conditions which define when the baby was born, or the birth weight. Although most babies born a few weeks early do well with minimal or no health problems, complications from prematurity and/or VLBW may lead to diagnosed medical conditions such as cerebral palsy, retinopathy of prematurity (ROP), Bronchio-pulmonary dysplasia (BPD) and later lung disorders, hearing and/or vision impairments, and periventricular leukomalacia (which can result in intellectual/motor disabilities), etc. If preterm birth or LBW/ELBW is the only medical documentation on record for a student, the team and/or P/HD teacher may want to have a discussion with the family about presenting symptoms, and whether additional medical diagnostic information is needed before pursuing qualification.

6. How does a team determine the primary disability category when a student qualifies under two or more categories?

The primary disability has the most significant impact on the student’s ability to participate in the educational setting. This can be a complex process, as some medical conditions can result in multiple and related areas of need, such as cerebral palsy. This condition can cause both physical and cognitive impairments, leading the team to ask themselves which impairment interferes most with the student’s ability to learn and participate in the educational environment. In some cases, when the adaptations to improve accessibility to the educational curriculum and environment are implemented, significant learning challenges stemming from cognitive impairment remain. In such cases, the IEP team may decide that the student would be best served under the
Developmental Cognitive Disability (DCD) category, with PI as a secondary category. Or, in the case of a severe/profound cognitive impairment, the SMI category may be considered (see FAQ #7). Under either special education category, students will have access to a wide array of related services to address all of their educational needs related to their disability.

Some diagnoses can also present as both physical and health-related conditions, requiring the team to consider which has the most impact on educational functioning. One would rarely qualify a student under PI and Specific Learning Disabilities (SLD), or PI and Emotional or Behavioral Disorders (EBD), but in such situations, the team should carefully consider the rationale for such a decision.

7. **When is it appropriate to consider qualification under Severely Multiply Impaired (SMI)?**

This question most frequently arises with students who have cerebral palsy and an accompanying cognitive impairment in the severe/profound range, but can also occur when a student is blind and has cerebral palsy, for example. In the case of PI and DCD-S/P, it is helpful to ask which impairment interferes most with the student's ability to learn and participate in the educational environment -- the physical impairment or the cognitive impairment. In some cases, when the adaptations to improve accessibility to the educational curriculum and environment are implemented, significant learning challenges remain. In such situations, the IEP team may decide that the student would be best served under the DCD-S/P category, or list PI as a secondary category. In most instances, a team will consider the SMI category, acknowledging that both the physical and cognitive deficits result in the need to recognize both categories equally. Regardless of the decision, students still have access to a wide array of related services to address all of their educational needs related to their disability.

8. **When an evaluation team is considering qualification for special education services under Physically Impaired criteria, are they required to qualify the student under component B (3), which indicates the presence of an achievement deficit of 1.0 SD or greater, in order to receive academic support?**

No; only one of the criteria in Item B must be met. If an evaluation team determines that there is an educational need related to the disability in an academic area, it can be addressed whether or not the student meets this third component of the Physically Impaired criteria. The educational need must be established in the evaluation report and related to the disability. Many evaluations are carried out in an untimed, very structured manner that is free of distractions, which may be significantly different than
the learning environment of the student. The educational need must be supported by observation and reflected in the evaluation report. The academic support should be provided by special education teacher(s) through a multidisciplinary team-teaching model.

9. Should cognitive ability testing be included in the evaluation plan for a student with a physical impairment?

While the criteria for Physically Impaired does not include a cognitive ability component, a cognitive or intellectual evaluation may be considered by the team if there seem to be needs in the area of information processing, memory, and/or other related higher learning modalities. This question will require careful consideration on the part of the team, and should take into account individual student needs, as well as the purpose for such testing. It is extremely important to remember that cognitive ability testing for students with physical impairments can be very challenging and complex, given the student’s potential difficulty in performing motor tasks quickly and efficiently. Although movement challenges may call into question test reliability, informal clinical observations during testing may reveal insights into the student’s processing and problem-solving capabilities. The evaluation planning team will need to carefully consider what information the ability testing will be able to provide; and if that information will be accurate and helpful in developing the student’s educational plan.

SERVICES

10. How early (at what age) can a P/HD teacher become involved with a student?

This can vary, depending upon the student’s educational needs, changing medical status, and current level of educational support. For students in Early Childhood Special Education (ECSE) programs, awareness of a medical diagnosis and related concerns about a student’s physical capabilities may prompt a request to include a P/HD teacher on the evaluation team. Occasionally, this request may not occur until age 7 for children served under the Developmentally Delayed (DD) criteria, at which time students must be identified by a more specific special education category such as Physically Impaired. However, if an ECSE team would benefit from the expertise, knowledge and resources that a P/HD teacher can offer, it is strongly recommended that they pursue PI qualification as early as possible.
Language in current Minnesota law is currently being revised to clarify the age range that P/HD teachers are licensed to serve. The proposed language defines the age range as ‘Birth - 21’ as compared to the existing language, “Prekindergarten to Grade 12”, which had historically been defined as being synonymous with starting at birth, just as Grade 12 is synonymous with students aged 18-21 who have not yet received their diploma.

There are a few teachers in the field who have a Physically Handicapped (PH) teaching license, which pre-dates the current P/HD license. Minnesota law stipulates that teachers with only the Physically Handicapped (PH) license will need to insure that they are part of a multidisciplinary team that includes an ECSE teacher in order to participate in the evaluation and service delivery for students with physical impairments who are younger than kindergarten age.

11. Is it possible for a student to receive only DAPE services on his/her IEP?

No. If a student has qualified for DAPE services, this means that the student has also qualified for ECSE services or a primary special education category, as reflected by DAPE criteria. As a result, services from the ECSE or primary category teacher (such as a P/HD teacher) must also be included on the IEP. Such services may be indirect and minimal in terms of frequency, but this would be determined by the team and based on evaluation results. A teacher licensed in the student’s qualifying category must also be involved in the initial evaluation, subsequent reevaluations, and annual IEP meetings. This will assure that the primary category teacher continues to be an active team member and consults with the DAPE instructor and other team members on a periodic basis. For more information on this topic, refer to Part X in this manual, Key Services & Supports in the Educational Setting.

12. Why would a student receive special education services under Physically Impaired if they have educational needs that would qualify them under the Specific Learning Disabilities (SLD) criteria?

The SLD criteria has an exclusionary statement that indicates that the student with a motor impairment may not meet the criteria under the category of SLD. However, there may be unique situations where it is determined through evaluation that a student’s primary reason for significant underachievement is the result of a learning disability unrelated to the motor impairment. However, it should be established that the motor impairment is not the cause of the learning disability. Such a student is in need of specially designed instruction related to the learning disability and not just adaptations or specialized instruction related to the physical impairment. If a student meets the criteria for both learning disabilities and physical impairment, there may be times when
that student will be determined by the educational team to have a learning disability with a secondary disability of a physical impairment. It would be extremely rare for the reverse situation to occur where a student would have a primary disability of PI, with SLD as a secondary disability.

13. Why are adaptations and compensatory strategies used with students with physical impairments, as opposed to teaching remediation skills?

In some cases, providing adaptations allows the student with a physical impairment more effective and independent access to learning tasks. Similarly, there will be situations when the student will utilize compensatory skills instead of continuing to pursue remediation strategies. A common example of this would be the area of handwriting. Some students with physical challenges will never develop functional handwriting skills even with individualized instruction and/or related services such as occupational therapy. In such a situation, the student might utilize compensatory strategies available through assistive technology, such as word processing or electronic dictation. However, there may be situations where remediation may be a viable option, depending on the individual student's skills. Do not assume that all students with physical impairments will use compensatory strategies for handwriting. Remember to document all adaptations on the IEP.

14. How do we grade students with physical disabilities?

The IEP team should follow the same educational guidelines provided for all special education students. If it is determined that grading should be different from the traditional system, the specifics for grading need to be determined on an individual basis by the IEP team and documented on the IEP. The IEP team may want to consider a continuum of options including a regular report card, a modified report card, or a narrative progress report that would be closely aligned with the IEP goals and objectives.

15. Are accommodations available for the Minnesota Graduation Standards and state tests for students who are physically impaired?

There are very specific accommodations that are allowed for students on the Basic Skills Tests such as a using a scribe, a word processor, or extended time. If the student needs additional accommodations to pass the Basic Skills test, the IEP team may decide to have the student receive a Pass/Individual score. All assessment-related accommodations should be addressed in the IEP. The IEP team may also consider modifications, an
alternate assessment, or exemption, although this latter option must be carefully weighed. There are more accommodations available for a student with a physical impairment when he or she is completing the high standards.

16. **At times, the amount of work that a student with a physical impairment can complete is limited. What about quality versus quantity of work completion?**

It may be appropriate for a student to complete a reduced number of items to demonstrate mastery of a concept, or to complete an adapted assignment as a result of the student's rate of writing or slower processing speed. This strategy is frequently used when there are many repetitions of similar problems. If an assignment is adapted, it is important that the student be able to demonstrate mastery of the presented skill range.

17. **Should a student with a physical impairment learn to handwrite if the handwriting is unlikely to be an attainable functional goal? What about learning cursive writing?**

The skills and needs of each individual student should be considered when deciding if and how to provide handwriting instruction. After considering the student's skills and the amount of instructional time required to teach handwriting, it may be concluded that the student will not be able to develop functional handwriting. Sometimes, the student can develop functional handwriting skills to complete math assignments or short writing tasks such as making a list. When cursive writing is introduced, it may be more appropriate for some students to participate in a modified cursive writing curriculum so that he or she can learn to read cursive writing and/or develop a signature. There are other alternatives to manual handwriting that are now available through technology, and should also be considered, including computer fonts that replicate a cursive handwriting style. Additionally, electronic signatures are now becoming a commonly accepted form on informal and legal documents. For a few students, cursive writing is easier and more functional than manuscript writing.
18. What are considerations for selecting alternative curriculum for students with physical impairments?

The IEP team should consider the student’s current level of performance in relation to his/her classroom, as compared to the academic expectations based upon assessment and actual classroom performance. At a minimum, considerations need to be given to written work production, reading ability, and processing time.

If a student has been involved in the regular academic curriculum with accommodations and adaptations for motor limitations and is not meeting classroom expectations for progress, the IEP team may determine that an alternative curriculum or functional curriculum will be more appropriate for the student. For example, a student who is nonverbal, or has a highly phonetic approach to reading instruction, may have significant challenges with traditional reading curriculum, but may do well with a modified sight word curriculum that is supplemented by basic phonics skills.

19. When is direct service provided to a student who qualifies under the PI category?

The need or appropriateness for direct service is an IEP team decision based on the student’s needs and related goals and objectives. Direct services,” means special education services provided by a teacher or related services professional when the services are related to instruction, including cooperative teaching. For more information on this and related service delivery topics, refer to Part VII in this manual, Services in the Schools.

20. If a student meets criteria and qualifies for special education services under the Physically Impaired category, who can provide the academic instruction if a student is in need of direct service?

Direct service can be provided by a licensed special education teacher, such as the P/HD teacher or a special education teacher in consultation with the P/HD teacher, based on the IEP team’s decision. Many P/HD teachers are itinerant and primarily or exclusively provide indirect consultation service in this low incidence category. If the IEP team feels that a special education teacher licensed in another area of special education (e.g., SLD, EBD, DD) is the best member of the IEP team to provide direct or indirect services, that teacher can provide that service even if the student does not meet the criteria represented by that teacher’s licensure area. However, in such situations it is imperative that the service provider have ongoing consultative support from the P/HD teacher.
21. P/HD teachers typically provide indirect service. What do indirect services entail?

Indirect services” means special education services which include ongoing progress reviews; cooperative planning; consultation; demonstration teaching; modifications and adaptation of the environment, curriculum, materials or equipment; and direct contact with the pupil to monitor and observe. Indirect service may be provided by a teacher or related service professional to another regular education, special education teacher, paraprofessional, support staff, parents and public and nonpublic agencies to the extent that the services are written in the pupil’s IEP and IFSP. Minn. R. 3525.4700 subp.8c. For more information on this and related service delivery topics, refer to Part VII in this manual, Services in the Schools.

22. Who is responsible for assuring that adaptations and accommodations identified in the IEP are in place?

The IEP manager is responsible for coordinating and communicating with team members as well as other teachers who work with the student about adaptations and accommodations, assuring that identified accommodations are being implemented. The district shall assign a teacher or licensed related service staff who is a member of the pupil’s IEP team as the pupil’s IEP manager to coordinate the instruction and related services for the pupil. The IEP manager’s responsibility shall be to coordinate the delivery of special education services in the pupil’s IEP and to serve as the primary contact for the parent. A district may assign the following responsibilities to the pupil’s IEP manager: assuring compliance with procedural requirements; communicating and coordinating among home, school, and other agencies; coordinating regular and special education programs; facilitating placement; and scheduling team meetings. Minn. R. 3525.0550

23. How could services provided by an educational paraprofessional be utilized with a student with a physical impairment?

Based on the student’s specific needs, the educational paraprofessional may provide physical assistance to facilitate optimal positioning, access to assistive technology and equipment, assistance with personal care needs, and to implement teacher-directed academic adaptations to educational activities. It is recommended that the paraprofessional foster a sense of independence and self-advocacy with the student whenever possible, as students with significant motor impairments are frequently dependent on others to assist with physical needs.
Fostering a sense of independence in a student can occur through increased decision-making, showing responsibility for working on and completing school assignments, as well as identifying needed accommodations and providing direction to the paraprofessional. If the paraprofessional is involved in academic activities, his/her role should be to reinforce concepts being taught by the classroom or special education teacher. Although the paraprofessional may carry out planned activities such as drill practice, the paraprofessional does not take the place of teacher interaction and instruction, nor should the paraprofessional provide initial instruction. The actual scope and sequence of instruction should be developed through the IEP team process, and taught by a licensed teacher. It is vitally important that the paraprofessional does not work in isolation of professional support, but rather receive guidance from teacher(s) and/or the IEP manager.

24. When are related services necessary?

Related services are necessary when they are needed to assist the child with a disability to meet educational goals. It is important to remember that related services are not limited to occupational therapy or physical therapy. Related services such as audiology, counseling services, school social workers, speech pathology, and school health services have been utilized as a related service to meet specific educational goals. For more information on this topic, refer to Part VII of this manual, Services in the Schools.

25. A student with a physical impairment typically has significant educational needs in the motor area. How does an IEP team maintain a balance between academic and motor needs when addressing the full school day, including functional movement, exercise, and activities of daily living?

The IEP team should determine the educational priorities based upon the needs of each individual student. The team will need to consider the age of the student, the degree of physical involvement, long term goals for independence, and the ‘cost’ of the motor tasks in physical energy and time. For one student, the team may decide that independence in activities of daily living is a priority, which may have an impact on the time available for academic instruction. In another situation, the IEP team may determine it is necessary to give priority to valuable classroom and peer experiences, while providing more direct assistance for physical activities. Such issues may change throughout the student’s school career, and at minimum, need to be considered annually during the development of the IEP.
26. How does a physician’s “prescription for service” influence IEP team decisions and service delivery?

The Physically Impaired criteria requires a medical diagnosis of a physical impairment by a medical doctor. The information that is provided from the medical community is very valuable in providing the necessary documentation, as well as assisting in identifying and addressing health-related needs in the school setting. However, the acknowledgement of a physician’s “prescription for service” can tempt teams to bypass mandatory due process procedures related to identification of educational needs and services. IEP teams clearly need to consider the medical information during the evaluation process and/or development of the Individualized Education Plan, but physicians are not in the position to determine educational placement or services, just as educators would not diagnose or prescribe medication.

27. What is the school’s responsibility in addressing specific therapy-related issues such as range of motion?

The answer to this question is provided in a manual entitled, OT and PT Services in the Schools- MN State Guidelines for Practice which states: “A child or family needs to be actively involved in the life-long maintenance of range of motion. The school therapist can facilitate this by incorporating flexibility into naturally occurring activities at school, including positioning, dressing, personal cares, physical education and recreational activities.” Range of motion information can be helpful for baseline and assessment data, but when not connected to real life skills, it becomes less useful. Using terms such as exercise, strengthening, stretching, as well as those listed above bring a more understandable, pragmatic, educational focus to the IEP discussion.

28. Do all students who meet qualification for criteria under the category of Physically Impaired require assistive technology to be successful in the educational setting?

There is no single answer for the provision of assistive technology for students with physical impairments. IDEA requires all IEP teams to consider assistive technology in planning for all students in special education. Assistive technology often can increase the functional skill level and increase independence in the educational setting for the student with a physical impairment. Adaptations, modifications, and other low-technology forms of support are also very appropriate to consider when developing a plan for a student with a physical impairment. Determining accommodations, including those that involve assistive technology is a team process. The Minnesota Assistive Technology Guidelines outlines a process for consideration of assistive technology (SETT process) and is available on the Minnesota Department of Education’s website.
29. Is it permissible to change or add to current IEP services when educational needs related to the specific academic area are not documented in the most recent student evaluation? Example: Special education services are initiated for a student who was evaluated and qualified for services under the PI category. Services initially focused on organizational/independent work skills. Later, it becomes apparent to the team that the student is also going to need some specialized instruction in math, which the team feels is related to his physical impairment. Does the team need to go back and conduct a re-evaluation, or can they justify adding the service to the existing IEP based on recent data collection and ongoing observations?

The IEP team (including the parents) should meet to address this new information. This ensures that everyone involved is aware of the new need and has input into the change. The paperwork documents the change in the student’s needs. A reevaluation is not required if the new need is a direct result of the student’s disability. (Minn. Rule 3525.2810 and 34 CFR Part 300 / D / 300.324 / b / i / ii)

30. Must a team conduct an evaluation prior to concluding that a student is no longer eligible for special education services?

Yes. A school district must evaluate a student with a disability, following proper evaluation procedures prior to determining that the student is no longer a child with a disability. For more information on this and other due process questions, go to MN Department of Education’s website (Compliance and Assistance, Q & A page).
Part XIV

Regional & Statewide Resources
For the P/HD Teacher
PROGRAMS & SERVICES

- **Minnesota Low Incidence Projects: [www.mnlowincidenceprojects.org](http://www.mnlowincidenceprojects.org)**
  This statewide program is funded through a grant from the MN Department of Education, and is designed to assist school districts across the state in fulfilling federal requirements in the areas of implementation of IDEA, professional development, and insuring the availability of high quality staff in the low incidence areas of special education. Technical assistance is offered as a major component of this project. Low incidence areas and services supported by this grant include: Physically Impaired (PI); Traumatic Brain Injury (TBI); DeafBlindness (DB); Developmental Cognitive Disabilities (DCD); Autism Spectrum Disorders (ASD); Severely Multiply Impaired (SMI); Developmental Adapted Physical Education (DAPE); School-Based Occupational & Physical Therapy (OT/PT); and Early Hearing Detection & Intervention (EHDI).

  The [PI and TBI webpages](http://www.mnlowincidenceprojects.org) provide many resources for the P/HD teacher and/or TBI specialist, including brochures, manuals, technical training materials, licensure information, service delivery considerations and guidelines, student evaluation protocol, electronic resources, information for families, and more. (Much of this information can also be found in the PI and TBI educator manuals.)

- **Minnesota Department of Education: [www.education.state.k12.mn.us](http://www.education.state.k12.mn.us)**
  The MN Department of Education provides oversight and support to all of Minnesota’s public schools and services. Many resources can be found on this site, including teacher licensure information, child count data, Minnesota rules and regulations, and much more.

- **Regional Low Incidence Projects:** These projects operate throughout the eleven educational regions of the state, providing coordination and support to educators who serve children and youth with low incidence disabilities, and their families. For a complete listing of Regional Low Incidence Facilitators (RLIF) and contact information, refer to the main website page of the MN Low Incidence Projects.

- **Statewide Low Incidence Specialists:** There are statewide low incidence specialists assigned to each of the low incidence special education areas. To locate information about a specific specialist, click on the Low Incidence Disability link on the main website page of the MN Low Incidence Projects.
PROFESSIONAL NETWORKS

- **Statewide Physical/Health Disabilities (P/HD) Network**
  There are approximately 140 members on the MN Physical/Health Disabilities Statewide Network, with approximately 70-80 members attending meetings on a regular basis, including Greater MN members who attend via ITV. There are 2 full day meetings held each year, in addition to a shorter spring network meeting held in conjunction with the annual Charting the C's/Cross-Categorical Conference, of which the P/HD Network is a conference partner. Past Network initiatives have addressed the topics of professional recruitment, licensure standards, post-secondary training, revisions to professional manuals, and development of additional resource materials. Meetings are facilitated by the Statewide PI specialist and a P/HD Network steering committee. For more information on the history of the Network, or how to become a member, contact your regional low incidence facilitator or the PI/OHD Statewide Specialists.

- **Statewide TBI Network**
  The Statewide TBI Educational Network is a representative network that was created in 2000 to bring individuals together who share a common goal of meeting the needs of children and youth with traumatic brain injury and their families. Toward this end, Network members address the issues of regional and state training, dissemination of/access to materials and resources, and special project development. Additionally, the Network serves as a link between regional teams and the statewide TBI specialist in an endeavor to identify local issues, training needs, and available resources. Educational regions throughout the State identify TBI specialists to serve as representatives on the Network, and are joined by other stakeholders, such as representatives from the Brain Injury Association of MN, rehabilitation and medical clinics/hospitals, state and local agencies, parents, and advocacy organizations. Meetings are held twice a year in the fall and spring. For more information on the history of the Network, contact the Statewide TBI specialist.

- **Regional P/HD and TBI Networks**
  All regions support regional network meetings, which occur periodically throughout the school year. These meetings provide an opportunity for regional resource sharing and trainings. For more information about a specific regional network, contact the Regional Low Incidence Facilitator.
STATEWIDE P/HD LIST SERVE

The State P/HD List Serve is available to licensed P/HD teachers, special education administrators, and other interested professionals who subscribe to this electronic service, and allows users to send/share information with other members of the list serve. Some typical uses include: Requesting information about a specific issue or question related to the provision of services, evaluation tools, disability-specific information, community resources, adaptations, etc. Users are asked not to include confidential information about a student that would be covered under the Data Privacy Act. PI, OHD and TBI conference brochures, trainings, IHE courses, surveys, resources, tools, state network meeting notices and minutes may also be posted. For more information on member subscription, directions for posting messages, professional standards and protocol, visit the MN Low Incidence Disabilities PI Resources webpage.

EDUCATOR MANUALS

Manuals can be accessed and/or downloaded from the MN Low Incidence Projects or MN Department of Education website, depending upon publication ownership.


- Minnesota Assistive Technology Manual (Anticipated revision 2012)

- Compliance Manual for Section 504 of the Rehabilitation Act of 1973 (Updated April 2011)
STATE CONTACTS

Barb Sisco, State Low Incidence Specialist; State OHD Specialist

Minnesota Department of Education

Email: Barbara.Sisco@state.mn.us
Phone: 651.582.8226

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Minnesota Low Incidence Projects

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Part XV

Physically Impaired Fact Sheets

(Listed alphabetically)

Arthrogryposis
Cerebral Palsy
Dystonia
Muscular Dystrophy
Osteogenesis Imperfecta
Post-Polio Syndrome
Spina Bifida
Spinal Cord Injury
Spinal Muscular Atrophy
Symptoms or Behaviors

• Normal Intelligence
• Normal speech
• Intact sensation
• Muscle weakness
• Internal rotation/deformity of shoulder
• Extension & pronation/deformity of the elbow
• Volar & vulgar deformity of the wrist
• Finger in fixed flexion & thumb-in-palm deformity
• Flexed, abducted, externally rotated hips, often with dislocation
• Flexion deformity of the knee
• Club foot deformity

About the Disorder

Arthrogryposis is a musculoskeletal disorder characterized by the presence of multiple joint contractures (limitation of the range of motion of a joint) at birth. In some cases, only a few joints may be affected. However, in the classic cases of Arthrogryposis Multiplex Congenita (AMC), hands, wrists, elbows, shoulders, hips, feet, and knees are affected. In the more severe cases, joints in the back and jaw can be affected as well. In addition to having joint contractures, children also experience muscle weakness, which further limits movement.

AMC is a nonprogressive congenital neuromuscular syndrome characterized by severe joint contractures, muscle weakness, and fibrosis. AMC occurs in 1 out of every 3,000 live births. There may be as many as 10 to 20 different arthrogrypotic disorders, all with similar joint manifestations. The most common form (43%) of AMC is amyoplasia, characterized by fatty and fibrous tissue replacement of the limb muscles.

There are many different causes of AMC, but typically it is a result of either problems with joint growth and development, decreased fetal movement (not enough room in the uterus to move), or problems with spinal development in the first 3 months of pregnancy. A diagnosis of AMC can sometimes be made during pregnancy. Ultrasounds at approximately 20 weeks gestation may show abnormal position of joints or lack of movements in joints and limbs indicating the disorder. Otherwise, the diagnosis can be made by an orthopedist based on clinical symptoms and findings. Muscle biopsies, blood tests, and clinical findings help rule out other possible disorders and provide evidence for AMC.

The primary joints involved (in order of decreasing prevalence) include the foot, hip, wrist, knee, elbow, and shoulder. AMC is typically symmetrical and involves all four extremities with some variation seen.

Typically, two forms are seen. First form: Flexed and dislocated hips, clubfeet (talipes equinovarus), extended knees, flexed elbows, flexed wrists and fingers. Second Form: abducted and externally rotated hips, flexed knees, clubfeet, internally rotated shoulders, extended elbow, pronated forearm, and flexed and ulnarly deviated wrists.

Other associated conditions include scoliosis, lung hypoplasia (underdevelopment) leading to respiratory problems, growth retardation, mid-facial hemangioma (benign tumor of dilated blood vessels), facial and jaw deformities, respiratory problems, and abdominal hernias. Cognition and speech are usually normal.

There is no cure for AMC; however, there are treatments that can help children live very full lives. For many, physical therapy has proven to be beneficial to strengthen muscles and improve range of motion. Splinting and bracing can also help improve range of motion. If these traditional treatments have not produced positive results, surgery may be necessary. Surgery can be done to put feet in position for standing and walking and can also be done to knees, hips, elbows, and wrists to achieve greater range of motion. And, in some cases, muscle and tendon transfers can be done to improve range of motion. AMC is not a progressive disorder, so it will not worsen with age. However, children must receive medical treatment to prevent joints from stiffening as they grow.

Most children with AMC have some walking ability. Bracing and other treatments mentioned above will help to make walking easier. AMC may be accompanied by other disorders, such as central nervous system disorder. However, in most cases, the long term outlook is positive. Most individuals with AMC possess normal intelligence and speech. They have a potential for functional mobility and are able to lead productive, independent lives.

Revised 2012
Educational Implications

Children with AMC usually possess normal intelligence and speech. The student may need support in dealing with self-image and acceptance from his/her peers. Physical therapy, occupational therapy, and adaptive physical education will be needed to address the student’s specific needs. Assistive equipment may be necessary, as well as an adapted classroom environment. Due to limited mobility, the student may need additional hall passing time. The student may need academic services provided when absent for long periods of time due to scheduled surgeries.

Instructional Strategies & Classroom Accommodations

Staff may need to provide:

- Curriculum modifications, such as: extra time for assignments, modifications to length of assignment, modified time limits, alternative testing and notetaking methods, adapted materials and environment, extended passing time, support from resource room
- May need assistance at lunch
- May not be able to write or inability to write as fast as other students. The student may need to do work orally, use a computer for written assignments, may need alternative note taking methods, or other handwriting accommodations
- May become tired easily from walking or other motor activities; should be allowed more time to get from one place to another
- May need assistance with daily classroom activities such as getting books out of book bag, etc.
- Check to see if the student can walk up steps
- An Individual Health Care Plan and Emergency Evacuation Plan should be developed and implemented

Note: Document all accommodations on the student’s IEP

Resources

The National Rehabilitation Information Center
National Organization for Rare Diseases (Arthrogryposis)

NIH/National Arthritis and Musculoskeletal and Skin Diseases Info. Clearinghouse
http://www.niams.nih.gov
Symptoms or Behaviors

• **Hypertonia or Spasticity:** Increased stiffness. Happens when the motor cortex and spinal cord are affected. Occurs in 60% of CP cases. Scoliosis is common with this characteristic.

• **Hypotonia:** Muscle weakness. Most infants with CP initially have hypotonia when born, especially in the neck and trunk. When the floppiness/weakness continues through the first year without spasticity or athetoid movement, the diagnosis of generalized hypotonia is given. Students with hypotonia often stand on the inside of their feet causing the ankles and legs to rotate inward and the toes to claw. Foot deformities can occur without the proper positioning – AFO-Ankle Foot Orthotics.

• **Athetosis or Athetoid or Dyskinetic:** Involuntary movements are present, especially in the arms, hands, and face. Happens when extrapyramidal tract of the nervous system is affected. Paying attention in the classroom can be especially hard for students with this characteristic as their own body movements distract them.

• **Choreoathetoid:** Characterized by wormlike athetoid movements.

• **Ataxia:** Characterized by an inability to achieve coordination in balancing and hand use. It is the predominant characteristic in 5-10% of CP cases. Occurs when the cerebellum is injured.

• **Mixed:** Most often CP is described as including more than one of the above characteristics. In such cases, it can be described as “mixed”.

About the Disorder

Cerebral Palsy is a general term most widely defined as “a disorder of movement and posture due to a defect or lesion of the immature brain.” A more detailed definition that is being pushed for international acceptance states “a group of disorders of the development of movement and posture, causing activity limitation, that are attributed to non-progressive disturbances that occurred in the developing fetal or infant brain. The motor disorders of cerebral palsy are often accompanied by disturbances of sensation, cognition, communication, perception, and/or behavior, and/or by a seizure disorder.”

**Words to Describe Severity:**

**Severe:** Total dependence in meeting physical needs; poor head control; perceptual and/or sensory integrative deficits prevent achievement of age-appropriate motor skills.

**Moderate:** Some independence in meeting physical needs; functional head control; perceptual and/or sensory integrative deficits interfere with achievement of age-appropriate motor skills.

**Mild:** Independent in meeting physical needs; potential to improve quality of motor and/or perceptual skills with therapy intervention; and potential for regression of motor skills without proper intervention.

Revised 2012
Educational Implications

- Students with moderate involvement usually require the most intensive therapy in an attempt to raise their level of independence. Students with severe involvement require school staff to be trained in positioning techniques to help prevent deformities and sores from developing.

- Students may need occupational therapy, physical therapy, speech therapy, and adaptive physical education (DAPE). Multiple services may often take students out of the classroom. Scheduling therapies around academic instruction should be attempted.

- Auditory learning is often an area of strength, as visual perception difficulties are common. Physically managing school materials may also be difficult, necessitating modifications to materials and equipment in the school environment. Assistive technology such as text to speech/scan and read software is often an appropriate accommodation, especially in the upper grade levels.

- Visual motor difficulties are common, so copying from the board can be difficult, along with other related drawing activities, and will require modifications.

- Identifying mobility options at a young age is crucial for students, allowing them to learn about their environment through physical exploration.

- Students may have an increased or decreased need for calories, depending on their metabolism and activity level.

- CP is not progressive, but if it isn’t properly managed with devices and therapy, a student’s physical status can worsen.

Instructional Strategies & Classroom Accommodations

- Consider modifying curriculum, materials, environment, and student testing; and provide the tools to do so, including assistive technology.

- Provide additional time and alternative methods when completing writing assignments, taking notes, etc.

- Provide organizational tools and instructional supports.

- Develop an evacuation plan if needed.

- Consider accommodations and supports for self-care needs.

Note: Document all accommodations on the student’s IEP.

Resources

United Cerebral Palsy
800-872-5827
www.ucp.org

National Center on Birth Defects and Developmental Disabilities (NCBDD)
www.cdc.gov/ncbddd/dd/ddcp.html

National Institute of Neurological Disorders and Stroke
800-352-9424
www.ninds.nih.gov/

Meeting the Needs of Students with Special Physical and Health Care Needs
Hill, Jennifer Leigh
Prentice Hall Publications
Symptoms or Behaviors

- Spooning of fingers
- Elbow & wrist flexion
- Foot in-turning
- Inversion at ankle
- Upward extension of big toe
- Turning of neck or “torticollis”
- Jaw or facial contortions
- Unexplained muscle pain
- Unexplained muscle weakness

About the Disorder

Dystonia is a neurological movement disorder characterized by involuntary muscle contractions which force certain parts of the body into abnormal, sometimes painful, movements or postures. Dystonia is highly variable in its manifestations. Anyone can manifest symptoms of dystonia; it is the third most common neurological disorder affecting approximately 200,000 people in North America. Medical researchers believe that dystonia results from an abnormality in the basal ganglia where messages that initiate muscle contractions are processed. Researchers suspect a defect in the body’s ability to process neurotransmitters which help cells in the brain communicate with each other.

Dystonia is described according to the part or parts of the body that are affected. If only one body part is involved, such as a hand, foot or the neck, the form is termed a “focal dystonia”. If two contiguous parts are involved, such as the face and neck, then it is termed a “segmental dystonia”. If two noncontiguous parts of the body are involved, such as the face and one leg, it is termed a “multifocal dystonia”. If one half of the body is involved, it is called a “hemidystonia”, and if both legs, as well as one additional body part are involved, then it is termed, “generalized dystonia”. A focal dystonia that progresses to become generalized, or generalized dystonia itself, are the most common parts observed in children. When dystonia is due to another identified disease, then it is called secondary dystonia. When dystonia is not caused by another disease or condition, it is called primary dystonia.

Primary dystonias includes the genetic dystonias and some adult-onset, focal dystonias. Secondary dystonias may be due to a wide variety of causes including cerebral palsy, metabolic diseases, head trauma, and others. Dystonia may occur at rest or with action. A feature of dystonia that distinguishes it from most other movement disorders is that a dystonic movement of one limb may be triggered by an attempted movement of a different limb. For example, a dystonic posture of the right hand may occur while the left hand is performing a rapid movement, or a dystonic posture of the foot may occur during walking. It is important to know that there is no abnormal muscle tone in children with dystonia. A dystonic limb may or may not have increased resistance to movement, presenting as either stiff or floppy, or changes with time.

Symptoms of dystonia in childhood appear between the approximate ages of 5 to 16, and are usually in the foot or in the hand. In generalized dystonia, the involuntary dystonic movements may progress quickly through the body and involve all limbs and the torso. When symptoms emerge during early childhood or in late adolescence, they often begin in the upper body parts with symptoms progressing slowly.

Revised 2012
Educational Implications

Dystonia can affect many different parts of the body. Early symptoms may include deterioration in handwriting after writing several lines. Also foot cramps and/or a tendency of one foot to pull up or drag which may occur suddenly or after running or walking long distances. The neck may turn or pull involuntarily, especially when the individual is tired or stressed. One or both eyes may blink uncontrollably and rapidly, rendering a person functionally blind. Other possible symptoms are tremors and voice/speech concerns. Over periods of time symptoms may be noticeable, widespread and unrelenting. At other times, there can be little or no progression. The constant movement of dystonia can be compared to working out 18 hours/day. For individuals whose sleep is disrupted by constant movement, dystonia can interfere with the ability to sustain effort, concentrate and complete educational tasks throughout the school day. Students with dystonia may have difficulty breathing or swallowing due to muscle involvement in the areas of the jaw or tongue. Students with dystonia may also experience severe pain or headaches which can affect the quality of school work. Associated stress and depression can aggravate and or increase the symptoms of dystonia.

Instructional Strategies & Classroom Accommodations

Curriculum modifications may include:

- Extra time for assignments
- Modified assignment length
- Extended passing time

Note: Document all accommodations on the student’s IEP.

Resources

Dystonia Medical Research
One East Wacker Dr., Suite 2430
Chicago, IL  60601-1905
Phone: 312-755-0198
Fax: 312-803-0138
www.dystonia-foundation.org

WE MOVE
204 W. 84th St.
New York, NY  10024
Phone: 212-875-8312
Fax: 212- 875-8389
www.wemove.org

Spasmodic Torticollis Dystonia
PO Box 28
Mukwonago, WI 53149
www.spasmodictorticollis.org
Phone: 262-56-9534
888-445-4588
Symptoms or Behaviors

Signs and symptoms of muscular dystrophy can vary widely, depending upon the type. See specific information in the column to the right.

About the Disorder

There are three main types of muscular dystrophy that most frequently affect children and youth: Duchenne, Facioscapulo-humeral, and Limb-Girdle. Duchenne is the most commonly diagnosed.

**Duchenne Muscular Dystrophy** usually develops in boys between the ages of two and six. Early signs are often overlooked. The child may have difficulty climbing stairs and rising from sitting or lying positions. There is a tendency to fall frequently. Later, the child may develop a waddling gait. Serum levels of the muscle enzyme CPK are elevated in Duchenne even before clinical signs of the disease appear. A distinctive characteristic of Duchenne is the seeming enlargement of calf muscles, caused by the replacement of muscle with deposits of fat. Progression is rapid with no remission and is marked by wasting of proximal muscles – particularly in the pelvic girdle – followed by involvement of the pectoral muscles, and finally of all muscle groups. In this type (the most common and severe type of muscular dystrophy), patients historically survived only until their early 20’s, but this has changed in recent years due to improved medical care. The hereditary pattern in Duchenne MD is of the recessive X-linked type, in which the mother transmits the defective gene almost exclusively to male children. There is a 50% probability that any female offspring will be a carrier of the defective gene.

**Facioscapulo-Humeral Muscular Dystrophy** usually occurs in early adolescence, occasionally as late as the mid-20’s, and sometimes in infancy. There is marked variability in the severity and onset of symptoms. Initial involvement occurs in the muscles of the face and shoulder girdle. There is a resulting lack of facial muscle control; difficulty in raising arms over the head, and a characteristic forward slope of the shoulders. The progression is typically slow, with plateaus of significant duration. Average life span is rarely shortened, although patients may suffer considerable disability. Trunk and leg muscles may become involved, and the person may be unable to walk. The hereditary pattern is autosomal dominant. In this form of inheritance, a single gene derived from one parent transmits a trait. The carrier of a dominant disease gene usually suffers from the same disorder. There is a 50% probability of incidence among offspring – male or female.

**Limb-Girdle Dystrophy** occurs anywhere from the first to the third decade of life. It begins in either the shoulder muscles or muscles of the lower trunk and upper legs. The symptoms vary with part of the body affected. When the shoulders are affected, the individual may have difficulty raising arms and lifting objects, and have drooping shoulders. If the legs and trunk are affected, the student may waddle, have frequent falls, and/or have difficulty rising from the floor, and climbing stairs. The progression of the disease varies. If it begins in the shoulder muscles, it is generally slower. Sometimes the progression is very rapid. The course is unpredictable, but most become severely by middle age. Life span is usually shortened. The hereditary pattern is autosomal recessive. Unless both parents carry the gene, each offspring has a 25% probability of being completely free of the hereditary defect. Sons and daughters are equally at risk.

Revised 2012
About the Disorder, continued

Other types of muscular dystrophy include Myotonic MD, Becker MD, Congenital Dystrophy, Distal MD, Opthalmoplegic MD and Oculopharyngeal Dystrophy. Myotonic MD may occur at any age, but is most frequently seen in adults. Becker MD is similar to Duchenne, but starts later in life and is less severe. The life span may be normal. Congenital Dystrophy takes place during the fetal period and the disease is already manifested at birth. The essential features include hypotonia, muscle weakness, and contractures. Distal MD involves the small muscles of the extremities, and is the rarest subgroup.

Educational Implications
- The rate of progression and related symptoms can vary, according to the type of MD. (See above descriptions.)
- The most common type, Duchenne, usually develops at an early age (boys aged 2 to 6), and may require early intervention services and/or accommodations. As they age toward adulthood, heart and breathing muscles are affected, and may require advanced medical care. Students may be more prone to upper respiratory infections. However, it’s important to note that there can be a wide variation in symptoms.
- Most boys with Duchenne MD may need to use a wheelchair by upper elementary/middle school age, although this can vary.
- Most boys with Duchenne MD have average intelligence, but about a third experience learning disabilities, and a small number may have significant cognitive deficits.
- General muscle weakness and wasting will eventually require a school team to consider accommodations related to mobility, school work completion that requires both fine and gross motor use, development of an emergency evacuation plan, and a customized array of specialized services that often include a Physical/Health Disabilities teacher, PT, OT, DAPE, school nurse, paraprofessional support, etc.

Instructional Strategies & Classroom Accommodations
- Consider modifying materials and environment, and provide the tools to do so, including assistive technology.
- Provide additional time and alternative methods when completing writing assignments, taking notes, etc.
- Provide organizational tools, instructional supports, and extra set or digital texts.
- Develop an evacuation plan if needed.
- Consider accommodations and supports for self-care needs.

Note: Document all accommodations on the student's IEP.

Resources

Muscular Dystrophy Association
http://www.mda.org

National Institute of Neurological Disorders & Stroke

Mayo Clinic/Muscular Dystrophy
http://www.mayoclinic.com/health/muscular-dystrophy/DS00200
## Symptoms or Behaviors

Signs and symptoms of OI may include:

- Frequent fractures
- Joint laxity
- Blue or gray whites of the eye
- Thin, smooth skin
- Easy bruising
- Spinal curvature
- Bowing of long bones
- Excessive sweating and heat intolerance
- Barrel-shaped rib cage (some)
- Triangular face (some)
- Dentinogenesis imperfecta (teeth affected, making them prone to cavities and cracking)
- Hearing loss (usually early adulthood, but some cases in childhood)

## About the Disorder

Osteogenesis Imperfecta (OI), commonly called brittle bone disease, is a genetic disorder in which bones break easily, often with little or no apparent cause. The literal definition of “Osteogenesis Imperfecta” means imperfect bone formation. OI is caused by genetic defects in the structure of type I collagen. Type I collagen is the major component of the connective tissues in bones, ligaments, teeth and the white outer tissue of the eyeballs (sclera). There are at least four types, I, II, III and IV, of OI that researchers have identified (additional types continue to be identified). The signs and symptoms range from mild to severe. Individuals with Type I (mild) have half the normal amount of collagen, but it is all structurally normal. Those individuals with Types II, III and IV (severe and moderate) OI have structurally abnormal collagen. These defects lead to weak bones that fracture easily. Most cases of OI are caused by a dominant genetic defect. Some children with OI inherit the disorder from a parent, and others born with OI have no family history of the disorder. In these cases, the genetic defect occurred as a spontaneous mutation. Individuals with OI have a 50% chance of passing it on to his or her child. The disorder occurs in one out of 20,000 to one out of 60,000 live births. OI can affect males and females of all races.

### Traits:

**Type I:** This is the most common and mildest form of OI. Bones fracture easily, with most fractures occurring before puberty. Stature is normal to near normal. Joints are loose and muscle weakness is present. The whites of the eyes usually have a blue, purple or gray tint. The face has a triangular shape and there is a tendency toward spinal curvature. Bone deformity is absent or minimal. Brittle teeth and hearing loss beginning in the early 20’s and 30’s is possible.

**Type II:** This is the most severe form. Type II is frequently lethal at or shortly after birth, often due to respiratory problems. At birth there are often numerous fractures and severe bone deformity. Stature is small and lungs are underdeveloped.

**Type III:** Babies often have fractures present at birth. X-rays may reveal healed fractures that occurred before birth. Individuals with type III have short stature, sclera have a blue, purple, or gray tint, loose joints and poor muscle development in arms and legs. Barrel-shaped rib cage, triangular face and spinal curvature are also characteristic. Respiratory problems are possible and bone deformity is often severe. Brittle teeth and hearing loss is possible.

**Type IV:** This type falls between Type I and Type III in severity. Bones fracture easily with most fractures occurring before puberty. Stature is shorter than average with mild to moderate bone deformity. Sclera are white or near white (normal in color). There is a tendency toward spinal curvature, rib cage is barrel-shaped and face is triangular. Brittle teeth and hearing loss is possible.

Diagnosis of OI is often based on clinical features. Clinical geneticists can also perform biochemical (collagen) or DNA tests that can confirm a diagnosis of OI in some cases.

There is no cure for OI. Treatment is directed toward preventing or controlling the symptoms, maximizing independent mobility, developing bone mass and muscle strength. Care of fractures, extensive surgical and dental procedures and physical therapy are often needed. Use of wheelchairs, braces and other mobility aids are often used with individuals with more severe types. “Rodding” is a surgical procedure that involves inserting metal rods through the length of long bones to strengthen them and prevent or correct deformities. Several medications and other treatments continue to be explored.

Revised 2012
Educational Implications

Children with a severe form of OI may have spent much of their early life lying on their back, either in the hospital or at home in casts. As a result, they have missed out on a range of “life experiences”. This may affect their confidence and early learning. Individuals with OI usually have average or better academic abilities with the exception of physical education. Alternative PE activities and adaptive PE (DAPE) is often needed to develop safe and life-long leisure/recreational activities. Homebound instruction may be needed due to school absences from bone fractures that may result in hospitalization or home recovery. Children with a chronic disease should be monitored for depression, frustration and poor self concept. Staff and students may need support to deal with the fear of fractures which may result in over-protection. Since individuals with OI are generally cognitively capable, it is important that they are given every opportunity to practice social skills, make decisions for themselves and gradually learn to be independent individuals.

Instructional Strategies & Classroom Accommodations

Staff may need to provide:

- Homebound instruction or work with parents/hospital staff to make sure schoolwork continues if out of school for extended time due to fractures or surgical procedures
- Aids for mobility, and such services as adaptive physical education and physical therapy (to improve bone strength)
- Aids for writing (felt tip pen for writing due to inability to sustain pressure) and other fine motor tasks
- Accommodations/adjustments for delayed speed of writing ( lax joints in hands increase effort and reduce stamina; may need to write with non-dominant hand due to fractures in other hand; in severe forms, may have short, bent arms reducing reach)
- School environment needs to reduce hazards such as items that could be tripped on or wet floors
- Appropriate times when a student may need help to avoid injuries such as recess, playground time, hallways, etc.
- Early release from classes- avoid crowded hallways
- Assistance in restroom, especially for individuals with short arms and/or wheelchair users
- In-service to classmates and school personnel to understand OI and foster a considerate attitude and healthy peer relationships
- Familiarity with safe handling of children with OI. Fractures can occur if a part of the body is slightly twisted, pushed or pulled. Ask parents and physical/occupational therapists to demonstrate safe techniques
- Ongoing hearing screenings
- Develop emergency evacuation plan (fire/tornado)
- Develop Health Plan for any medical procedures and/or medications
- Information readily available for substitute teachers

**Note:** Document all accommodations on the student’s IEP.

Resources

**Osteogenesis Imperfecta Foundation**
804 W. Diamond Avenue
Suite 210
Gaithersburg, MD 20878
Telephone: 1-800-891-BONE
Internet Address: [http://www.oif.org](http://www.oif.org)
E-mail: bonelink@oif.org

**National Institutes of Health**
**Osteoporosis and Related Bone Diseases National Resource Center**
2 AMS Circle
Bethesda, MD 20892
Telephone: 1-800-624-BONE
Internet Address: [http://www.osteo.org](http://www.osteo.org)
E-mail: NIAMSBoneInfo@mail.nih.gov

**Growing Up with OI: A Guide for Families and Caregivers**
Osteogenesis Imperfecta Foundation
Gaithersburg, MD.
(15 chapter volume on OI)

For Children:
**Jason’s First Day!**
Available from OI Foundation

Resources for School
(available from OI Foundation)
**Plan for Success: An Educator’s Guide to Students with OI**
(video and booklet)

**Going Places**
(video and discussion guide)

**OI: A Guide for Nurses**
About the Disorder

Post-polio syndrome is an illness in the nervous system. It can arise 15 to 50 years after a person has polio. It affects a person’s muscles and nerves. It causes a person to have low energy, fatigue, and muscle or joint pain. Having post-polio syndrome doesn’t mean that a person has polio again. Unlike polio, post-polio syndrome does not spread from person to person.

Symptoms of post-polio syndrome tend to show up very slowly. The main symptoms are new muscle weakness, fatigue, and pain in the muscles and joints. Muscles that had nerve damage from polio may get weak and waste away because of post-polio syndrome. With post-polio syndrome, muscles that a person didn’t realize had been affected by polio may have weakness. Some people with post-polio syndrome also have problems with swallowing, breathing, sleeping, and tolerating cold temperatures.

Causes

Post-polio syndrome most likely arises from the damage left over from having polio. The polio virus harms the nerves that control muscles, and it makes the muscles weak. If a person had polio, he/she may have gained back the use of his/her muscles. But the nerves that connect to the muscles could be damaged without a person knowing it. The nerves may break down over time and cause a person to have weak muscles again. Researchers are studying other possible causes of post-polio syndrome. One theory is that the immune system plays a role.

Treatment

Post-polio syndrome is a condition that a person may have for the rest of his/her life. The aim of treatment is to help a person control symptoms and learn ways to stay active in spite of his/her muscle weakness. A person can manage his/her symptoms with a balance of physical activity and rest, ice and heat, pain medicine, and a healthy diet. Some people use canes, braces, and physical therapy. All of these things can help a person stay active.
Educational Considerations

Some people experience PPS-related fatigue as a flu-like exhaustion that worsens as the day progresses. This type of fatigue can also increase during physical activity, and may cause difficulty with concentration and memory. Others experience muscle fatigue, a form of muscle weakness that increases with exercise and improves with rest. Muscles should not be overused. Curriculum modifications and adaptations should be made to meet students’ needs, such as extended time, shortened assignments, and the assistance of a scribe. Affected students may also need to receive occupational therapy, physical therapy, and/or Developmental/Adaptive Physical Education during their school day. In addition, for some students with PPS, reliving their childhood experiences with polio can be a traumatic and even terrifying experience. Any mental health concerns should be addressed.

Instructional Strategies & Classroom Accommodations

- Monitor energy level closely; monitor physical expectations in Physical Education class if needed
- make accommodations for potential absences and homebound services if necessary
- Modify assignment due dates and the amount of handwriting
- Provide scribes or assistive technology for lengthy work completion, tests, and/or notetaking

Resources

National Institute of Neurological Disorders and Stroke/ NIH Neurological Institute
P.O. Box 5801
Bethesda, MD 20824
www.ninds.nih.gov
Tel: (800) 352-9424 or (301) 496-5751

Post-Polio Health International
4207 Lindell Blvd. #110
St. Louis, MO 63108-2930
info@post-polio.org
http://www.post-polio.org
Tel: 314-534-0475

March of Dimes Foundation
1275 Mamaroneck Avenue White Plains, NY 10605
askus@marchofdimes.com
http://www.marchofdimes.com
Tel: 914-428-7100 888-MODIMES (663-4637)

Online Resources


http://www.christopherreeve.org/site/c.mtKZKgMWKwG/b.4453219/k.CE80/PostPolio_Syndrome.htm
Symptoms or Behaviors

• Spina bifida develops during the first month after conception – usually before a woman even knows she is pregnant. Although scientists have not identified the precise cause of this birth defect, they believe it results from a combination of environmental and genetic factors.

• Approximately 40% of all Americans may have spina bifida occulta, but because they experience little or no symptoms, very few of them ever know that they have it. The other two types of spina bifida, meningocele and myelomeningocele, are known collectively as “spina bifida manifesta”, and occur in approximately one out of every thousand births. Of these infants born with “spina bifida manifesta”, about 4% have the meningocele form, while about 96% have myelomeningocele form. It is the second most common birth defect.

About the Disorder

Spina bifida develops during the time when the neural plate, a sheet of cells along the back of the fetus, forms the neural tube. In fetuses with spina bifida, parts of the neural plate fail to form a tube. Spina bifida occulta usually has no obvious symptoms and may be noticed on routine x-rays. A defect in one or more of the vertebrae is present but there is no damage to the spinal cord. The skin over the defect may be dimpled or pigmented or may have hairy patches.

Meningocele is when the meninges protrude through the bony defect producing a sac filled with cerebrospinal fluid. Myelomeningocele refers to the most severe form when the spinal cord, nerve roots, or both protrude into the sac. Neurological deficits are usually present causing paralysis of muscles in the legs and lower trunk area. Skin sensations may be impaired or absent and bladder and bowel incontinence may be present.

The effects of myelomeningocele, the most serious form of spina bifida, may include muscle weakness or paralysis below the area of the spine where the incomplete closure (or cleft) occurs, loss of sensation (pain, temperature, pressure) below the cleft, and loss of bowel and bladder control. In addition, fluid may build up and cause an accumulation of fluid in the brain (a condition known as hydrocephalus). A large percentage (70%-90%) of children born with myelomeningocele have hydrocephalus. Hydrocephalus is controlled by a surgical procedure called “shunting”, which relieves the fluid buildup in the brain. If a drain (shunt) is not implanted, the pressure buildup can cause brain damage, seizures, or blindness. Hydrocephalus may occur without spina bifida, but the two conditions often occur together.

The types and severity of a patient’s symptoms are determined by the particular spinal nerves involved. All nerves below the defect usually are affected. Therefore, the higher the spina bifida occurs on the back, the greater the amount of nerve damage and loss of muscle function and sensation. If a child’s upper thoracic cord and nerves are affected, for example, the lower limbs may be totally paralyzed and normal walking will be impossible. But a child with a lesion at the low sacral nerve level will have relatively mild paralysis and bladder and bowel problems.

Revised 2012
Educational Implications

• Visual perception problems which may cause difficulty with spatial discrimination, figure ground perception, and eye tracking
• Language difficulties in reasoning and comprehension, auditory decoding, and auditory association
• Inappropriate and bizarre language usage
• Reading problems in comprehension and content
• Math difficulty, especially affecting math reasoning skills
• Distractibility and inattentiveness
• Organizational problems
• Students with spina bifida may have abstract thinking difficulties. They need concrete beginnings/endings, need to experience materials, and to be an active participant
• Allow extra time to process questions and come up with answers
• Organizational skills and auditory/visual processing should be monitored
• Poor handwriting skills; may need written work modifications/accommodations and may need handwriting alternatives
• Sensory integration problems including late or non-established dominance, hand weakness, poor motor control, problems crossing midline, poor kinesthetic and tactile feedback, tactile defensiveness, and postural insecurity
• May need support to develop independent self-care skills and a consistent bowel/bladder management plan (this may include catheterization performed by school personnel and/or student)
• Will need frequent change in positions to avoid development of pressure sores
• School staff should recognize and accommodate the need for frequent absences due to medical appointments, procedures, and surgeries
• School personnel should be aware of the necessary medications and their side effects
• School staff should be aware of the signs of shunt malfunction/infection
• Speech Language Clinician may be involved to help with language development
• Often need involvement from OT/PT/DAPE staff

Instructional Strategies & Classroom Accommodations

• Consider modifying curriculum, materials, environment, and student testing; and provide the tools to do so, including assistive technology.
• Provide additional time and alternative methods when completing writing assignments, taking notes, etc.
• Provide organizational tools and instructional supports.
• Develop an evacuation plan if needed.
• Consider accommodations and supports for self-care needs.

Note: Document all accommodations on the student’s IEP.

Resources

National Dissemination Center for Children and Youth with Disabilities
http://nichcy.org

Mayo Clinic Fact Sheet
www.mayoclinic.com/health/spinabifida/DS00417

National Institute of Neurological and Stroke
http://www.ninds.nih.gov/conditions/spina_bifida/spina_bifida.htm

Spina Bifida Association
www.spinabifidaassociation.org
Symptoms or Behaviors

The most common issue after a spinal cord injury is loss of function such as mobility or feeling. Individual symptoms vary with the location of the injury. Possible complications associated with spinal cord injury include:

- Skin breakdown (as a result of excessive pressure from immobilization)
- Osteoporosis and fractures (as a result of the lack of weight-bearing exercises)
- Pneumonia, aspiration (restriction in respiratory function, termed restrictive lung disease)
- Respiratory dysfunction
- Spasticity
- Autonomic dysreflexia (resulting in dangerously high blood pressure)
- Orthostatic hypotension (a drop in blood pressure)
- Cardiovascular disease
- Neuropathic (nerve generated)/spinal cord pain
- Bowel management difficulties
- Urinary tract problems
- Deep vein thrombosis and pulmonary embolism
- Weight control issues
- Thermo-regulation issues

About the Disorder

A spinal cord injury (SCI) usually begins with a sudden, traumatic blow to the spine that fractures and dislocates vertebrae. The damage begins at the moment of injury when displaced bone fragments, disc material, or ligaments bruise or tear into spinal cord tissue. The injury causes fractures and compression of the vertebrae which then crush and destroy the axons (extensions of nerve cells that carry signals up and down the spinal cord between the brain and the rest of the body), disrupting that communication so that messages no longer flow past the damaged area. This may result in loss of function such as mobility or feeling. Besides an injury, spinal cord damage can also occur from such diseases as polio, spina bifida, or Friedreich’s Ataxia.

The extent of the communication breakdown is dependent on the severity and location of the injury. The spinal cord does not have to be severed for a loss of functioning to occur. Spinal cord injuries are classified as either complete or incomplete. A complete injury means that there is no function below the level of the injury, no sensation, and no voluntary movement. Both sides of the body are affected. An incomplete injury means that there is some functioning below the primary level of injury. A person with an incomplete injury may be able to move one limb more than the other, may be able to feel parts of the body that cannot be moved, or may have more functioning on one side of the body than the other.

The level of injury is helpful in predicting what parts of the body might be affected by paralysis and loss of function. In general, the higher in the spinal column the injury occurs, the more dysfunction a person will experience. The eight vertebrae in the neck are called the cervical vertebra. The top is C-1, the next is C-2, etc. Cervical SCIs usually cause loss of function in the arms and legs, resulting in quadriplegia, and injuries above the C-4 level can result in the loss of many involuntary functions including the ability to breathe, necessitating the use of a ventilator or breathing aids. The twelve vertebrae in the chest are called the thoracic vertebrae. Injuries in the thoracic region usually affect the chest and the legs and result in paraplegia. The vertebrae in the lower back are the lumbar vertebrae, and the five sacral vertebrae run from the pelvis to the end of the spinal column. Injuries to these lower vertebrae generally result in some loss of functioning in the hips and legs, as well as trunk control and abdominal muscle control. Besides the loss of sensation and motor functioning, individuals with SCI also may experience dysfunction of the bowels and bladder, sexual dysfunction, low blood pressure, inability to regulate blood pressure effectively, reduced control of body temperature, inability to sweat below the level of injury, and chronic pain.

There are about 10,000 new SCIs every year; the majority of them (82%) involve males between the ages of 16 and 30.
Educational Implications
After a SCI, the child and his/her family will need support and understanding as they struggle with the implications of the injury. Extensive medical treatment, evaluation, and rehabilitation will be involved, resulting in the child’s absence from school. After injury there will likely be a period of hospitalization, followed by clinic and rehabilitation appointments.

When the child returns to school, his/her loss of function will determine the extent and amount of educational accommodations and services that will be required. It is important that school staff be knowledgeable about the student’s injury and recovery, as well as his/her functional ability and independence. The teacher may want to contact the student’s parents to obtain the following information before the student returns to school:

- Specific injury and effects, if any, on the child’s functioning
- Any medications or specialized procedures, when it is administered, what potential side effects are
- Approximate schedule of upcoming appointments that may result in the child’s absence
- Limitations, if any, on the child’s activities (with updates)
- What the child knows about the injury & related emotional needs
- For younger children, what the family would like classmates and school staff members to know
- For adolescents, whether the student wishes to talk directly with teachers about any of the above points
- For adolescents, whether the student is able to take responsibility for his/her own health concerns

Research supports the importance of physical exercise, regardless of functional capabilities. Based on the nature of the injury, individuals with SCI can participate in almost all physical activities with modifications.

Instructional Strategies & Classroom Accommodations

- Environmental modifications for greatest mobility and independence
- Curriculum modifications (extra time for assignments, modified time limits, alternative ways to receive information, alternative ways to evaluate)
- Alternative note-taking methods, provision of teacher outlines
- Absences may require repeated instruction, modified requirements as noted above
- Tutorial services/homebound instruction when necessary
- Emotional support (counselor, school social worker, or psychologist) for assistance in dealing with implications of loss of function
- Assistance in learning adaptive techniques to accomplish educational tasks
- Assistive technology as necessary

Note: Document all accommodations on the student’s IEP.

Resources

Christopher Reeve Paralysis Foundation/Paralysis Resource Center
636 Morris Turnpike Suite 3A
Short Hills, NJ 07078
info@crpf.org; research@crpf.org
http://www.christopherreeve.org
Tel: 973-379-2690; 800-225-0292
Fax: 973-912-9433

National Spinal Cord Injury Association
1 Church Street #600
Rockville, MD 20850
http://www.spinalcord.org
info@spinalcord.org
Tel: 800-962-9629
Fax: 301-881-9817

National Institute of Neurological Disorders and Stroke
http://www.ninds.nih.gov

Spinal Cord Injury Information Network
http://www.spinalcord.uab.edu/

Spinal Cord Injury Resource Center
http://www.spinalinjury.net/

Paralyzed Veterans of America (PVA)
801 18th St NW
Washington DC 20006-3517
800-424-8200
http://www.pva.org
info@pva.org
Spinal Muscular Atrophy

About the Disorder

Spinal Muscular Atrophy (SMA) is a rare, inherited disease that is characterized by a progressive loss of muscle control, movement, and increased weakness due to the loss of motor neurons in the spinal cord. Proximal muscles (those closest to the spine) are most severely affected. Cognitive ability, emotional development, and sensory nerves are unaffected. SMA has a wide range of severity but all people with SMA will either never acquire or will progressively lose the ability to walk, stand, sit, and eventually move. The age of onset of SMA varies but most individuals show symptoms of the disease during infancy or toddler years. Respiratory illness is more common in individuals with SMA, as are spinal and bone deformities. A quality multidisciplinary approach to care which can include physical therapy, occupational therapy, respiratory therapy, nutritional care etc. can improve quality and length of life for the individual with SMA.

Different Forms of SMA:

Type I; Acute SMA (Werdnig-Hoffman Disease): The general age on onset of Type I is between birth and 6 months. It is characterized by generalized muscle weakness, weak cry, trouble swallowing and suckling, breathing distress, and inability to sit without support. Type 1 generally progresses more quickly than the other types of SMA.

Type II: The generally age of onset is between 6 and 18 months. Muscles closest to the center of the body such as the shoulders, hips, thighs, and upper back are most severely affected. Respiratory muscles can also be affected and spinal curvature issues need to be monitored and treated appropriately. Type II usually progresses slowly.

Type III (Kugelberg-Welander Disease): The general age of onset is after 18 months, and, similar to other forms, the muscles closest to the spine are most severely affected. The disease progresses slowly and the ability to walk can be maintained into adulthood and life span is generally not affected.

Most doctors consider the different SMA types to be on a continuum of severity and do not make rigid predictions about muscle weakness and life expectancy.

Symptoms or Behaviors

Varying degree of progression in lack of muscle control and movement

Increased proximal muscle weakness

Cognitive, emotional and sensory nerves unaffected

Age of onset varies, but most often seen during infancy/toddler years

At risk for respiratory illnesses, spinal and bone deformities
Educational Implications

Given that cognitive abilities are generally not affected by this progressive muscle disorder, many of the educational implications center around the provision of accommodations to the environment and adaptations to equipment and materials in the educational setting. In addition to the examples listed below, the team should be aware of some of the following considerations: Students with Type I typically require wheelchairs, and will require full access in and around the building and classroom, as well as modified desks and lockers. They may also require special transportation with a lift bus. Given the higher risk for respiratory illnesses, a school nurse should be considered as a possible team member, and an Individualized Health Plan (IHP) may need to be developed in addition to the IEP. Transition planning will need to take into consideration some of the physical/health/motor needs that may impact vocational/post-secondary options, and start connecting the student and his/her family with the necessary resources and agency support to ensure success in adult settings.

Instructional Strategies and Classroom Accommodations

- Meet frequently with parents to discuss student’s current medical status, strengths, interests, specific needs
- Prepare for frequent absences and have a plan in place to communicate with the student’s family
- Provide extra textbooks, notes, and assignments for home; or create electronic options
- Provide adapted materials such as a slant-board, pencils, word processor/computer, software, etc.
- Provide additional time for transitions
- Determine the appropriate amount and type(s) of physical activity for the student

Note: Document all accommodations on the student’s IEP.

Web Resources

http://www.fightsma.org/
http://www.smafoundation.org/
http://www.fsma.org/
http://www.mdausa.org/

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Part XVI

Appendices

PI Criteria Checklist

Organizational/Independent Work Skills/Motor Skills Checklists

Protocol Form: Initial Evaluation Following Hospitalization

Protocol Form: Students with Existing IEPS Following Hospitalization

Emergency Evaluation Plan Template

Itinerant Job Description
Physically Impaired Criteria Checklist

State Definition
“Physically Impaired” means a medically diagnosed chronic, physical impairment, either congenital or acquired, that may adversely affect physical or academic functioning and result in the need for special education and related services.” Minn. R 3525.1337, subp. 1

Criteria
A pupil is eligible and in need of special education instruction and services if the pupil meets the criterion in item A and one of the criteria in item B.

A. There must be documentation of a medically diagnosed physical impairment:

____________________________________________________________________
Diagnosis/Physician’s name/Date

B. The pupil’s:

____ 1) Need for special education instruction and service is supported by a lack of functional level in organizational or independent work skills as verified by a minimum of two or more documented, systematic observations in daily routine settings, one of which is completed by a physical and health disabilities teacher;

Document systematic observations in daily routine settings, one of which is completed by a teacher licensed in the area of physically handicapped or physical and health disabilities.

____________________________________________________________________
Observation 1 - Who/Date/Where

____________________________________________________________________
Observation 2 - Who/Date/Where
or

2) Need for special education instruction and service is supported by an inability to manage or complete motoric portions of classroom tasks within time constraints as verified by a minimum of two or more documented, systematic observations in daily routine settings, one of which is completed by a physical and health disabilities teacher;

Document two or more systematic observations in daily routine settings, one of which is completed by a teacher licensed in the area of physically handicapped or physical and health disabilities.

Observation 1 - Who/Date/Where

Observation 2 - Who/Date/Where

or

3) Physical impairment interferes with educational performance as shown by an achievement deficit of 1.0 standard deviation or more below the mean on an individually administered nationally normed standardized evaluation of the pupil's academic achievement.

*Attach to this checklist the documentation of the physical impairment, documentation of observation and/or achievement testing.
# Infant and Toddler Organization and Independent Motor/Play Skills Checklist

Child’s Name: ___________________________  Child’s Age: ___________________________

Environment: ___________________________  Setting: _____________________________

Date Completed: _________________________  Completed By: _________________________

<table>
<thead>
<tr>
<th>Organization/Play Skills</th>
<th>Independent</th>
<th>Needs Assistance</th>
<th>Comments/Adaptations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shows interest in</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environment (0-3 months)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>People (0-5 months)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tracking</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visually tracks (3 months)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Tracks sounds (6 months)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Expressive Communication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cries to get needs met (0-6 months)</td>
<td></td>
<td></td>
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<tr>
<td>Repeats 1 or more single syllable vowel sounds (6-12 months)</td>
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<tr>
<td>Speaks 10 to 20 words (12-18 months)</td>
<td></td>
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<tr>
<td>Speaks 2 to 3 word phrases (24-36 months)</td>
<td></td>
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<tr>
<td>Receptive Communication</td>
<td></td>
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<td>-------------------------</td>
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<tr>
<td>Turns head to sound (0-6 months)</td>
<td></td>
<td></td>
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<tr>
<td>Associates spoken words with familiar objects/people (6-11 months)</td>
<td></td>
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<td></td>
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<tr>
<td>Points to objects/body parts/people (15-9 months)</td>
<td></td>
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<tr>
<td>Follows 3 or more verbal commands (12-23 months)</td>
<td></td>
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<tr>
<td>Follows 2 to 3 step verbal commands (36-47 months)</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Reasoning</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Searches for hidden toy previously seen (12 months)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uses tool to get desired object out of reach (16-19 months)</td>
<td></td>
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<tr>
<td>Attempts to activate a device with a switch (20-23 months)</td>
<td></td>
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</tr>
<tr>
<td>Matches objects (28-31 months)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Orient objects (e.g. book) (32-35 months)</td>
<td></td>
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</tr>
<tr>
<td>Responds to directive to give 1 and 1 more (36-47 months)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Responds to same or different (36-42 months)</td>
<td></td>
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</tr>
<tr>
<td>Social Play</td>
<td></td>
<td></td>
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<tr>
<td>-------------------------------------------------------------------------------------------------</td>
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<td>---</td>
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</tr>
<tr>
<td>Smiles to image in mirror (3-5 months)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Participates in game like peek-a-boo (6-11 months)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discriminates between familiar and unfamiliar persons (6-11 months)</td>
<td></td>
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</tr>
<tr>
<td>Shows interest and plays with other children (12-17 months)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shows interest and plays with other children (12-17 months)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chooses toy and plays independently (24-27 months)</td>
<td></td>
<td></td>
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<tr>
<td>Shares toy with adult prompts (32-35 months)</td>
<td></td>
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<tr>
<td>Greets familiar adults spontaneously (24-35 months)</td>
<td></td>
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</tr>
<tr>
<td>Participates in pretend play (24-27 months)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Sometimes expresses feelings with words (36 months)</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Motor</th>
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</thead>
<tbody>
<tr>
<td>Positioning and Mobility</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Holds head up while in sitting (0-5 months)</td>
<td></td>
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<tr>
<td>Rolls over tummy - back (3-5 months)</td>
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</tr>
<tr>
<td>Rolls over back to tummy (6-8 months)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Developmental Milestone</td>
<td>Age Range</td>
<td></td>
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<tr>
<td>-------------------------</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Sits without support</td>
<td>6-11 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulls to stand</td>
<td>6-11 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creep/Crawl</td>
<td>8-11 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stands alone</td>
<td>11-15 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walks independently</td>
<td>14-15 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Squats/stoops to pick up object</td>
<td>12-17 months</td>
<td></td>
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<tr>
<td>Carries large object</td>
<td>12-17 months</td>
<td></td>
<td></td>
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<tr>
<td>Kicks stationary object without falling</td>
<td>18-23 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Throws ball</td>
<td>18-23 months</td>
<td></td>
<td></td>
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<tr>
<td>Manipulation of object/toy/hand</td>
<td>2-6 months</td>
<td></td>
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<tr>
<td>To mouth</td>
<td>2-6 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Completes 2-handed manipulation/play</td>
<td>10 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grabs and holds object</td>
<td>4-6 months</td>
<td></td>
<td></td>
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<tr>
<td>Releases object</td>
<td>8-9 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Turns pages of a book</td>
<td>9-12 months</td>
<td></td>
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<tr>
<td>Feeding</td>
<td></td>
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<tr>
<td>---------------------------------------------</td>
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<td></td>
</tr>
<tr>
<td>Coordinates suck, swallow, breathe (0-2 months)</td>
<td></td>
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<tr>
<td>Holds bottle to feed self (6-11 months)</td>
<td></td>
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<tr>
<td>Feeds self-finger food (6-11 months)</td>
<td></td>
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<tr>
<td>Ceases drooling (9-11 months)</td>
<td></td>
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<tr>
<td>Feeds self with spoon without spills (12-15 months)</td>
<td></td>
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<tr>
<td>Independently drinks from cup with spills (12-15 months)</td>
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<tr>
<td>Eats entire meal without assistance (16-19 months)</td>
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<tr>
<td>Toileting</td>
<td></td>
<td></td>
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<tr>
<td>Regularly expresses need to go to bathroom</td>
<td></td>
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<tr>
<td>Toilet trained during the day (36 months)</td>
<td></td>
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<tr>
<td>Washes and dries hands independently (36-47 months)</td>
<td></td>
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<tr>
<td>Dressing</td>
<td></td>
<td></td>
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<tr>
<td>Pulls off hat, socks, and mittens (12-16 months)</td>
<td></td>
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<tr>
<td>Undresses completely with help for fasteners (20-23 months)</td>
<td></td>
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<tr>
<td>Puts on simple clothing without assistance (24-35 months)</td>
<td></td>
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<tr>
<td>Puts on shoes (36-47 months)</td>
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<tr>
<td>Fine Motor Control</td>
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<tr>
<td>Holds object with fingers against heal of palm (0-5 months)</td>
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<tr>
<td>Pulls open drawers and cupboard doors (6-11 months)</td>
<td></td>
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<tr>
<td>Picks up small finger food with several fingers in opposition (6-11 mos.)</td>
<td></td>
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<tr>
<td>Picks up small finger food with ends of thumb and fingers using an overhand approach (10-14 months)</td>
<td></td>
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<tr>
<td>Imitates crayon strokes (16-19 months)</td>
<td></td>
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<tr>
<td>Builds 3 block tower (16-19 months)</td>
<td></td>
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<tr>
<td>Completes 3 piece form board puzzle (20-23 months)</td>
<td></td>
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<tr>
<td>Opens door by turning knob (24-35 months)</td>
<td></td>
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<tr>
<td>Strings 4 large beads (24-36 months)</td>
<td></td>
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<tr>
<td>Copies vertical line (36-47 months)</td>
<td></td>
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<tr>
<td>Uses scissor to cut paper (36-47 months)</td>
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</tbody>
</table>

Additional concerns (including sensory, social, behavior, motor, and communication):
**PREKINDERGARTEN-KINDERGARTEN ORGANIZATIONAL AND INDEPENDENT WORK SKILLS/MOTOR SKILLS CHECKLIST**

**Student’s Name:** _________________________  **Grade:** _____________________________  
**School:** __________________________________  **Setting:** ____________________________  
**Date:** ____________________________________  **Completed By:** ___________________


**Curriculum:** ___regular ___modified ___alternative

<table>
<thead>
<tr>
<th>Organizational Skills</th>
<th>Comments/Adaptations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follows natural environment or classroom routines</td>
<td></td>
</tr>
<tr>
<td>Follows classroom rules</td>
<td></td>
</tr>
<tr>
<td>Follows classroom schedules</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Work Skills</th>
<th>Comments/Adaptations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follows 1-2 step directions</td>
<td></td>
</tr>
<tr>
<td>Engages in groups</td>
<td></td>
</tr>
<tr>
<td>Begins task/activity</td>
<td></td>
</tr>
<tr>
<td>Corrects mistakes given verbal feedback</td>
<td></td>
</tr>
<tr>
<td>Knows when task/activity is complete</td>
<td></td>
</tr>
<tr>
<td>Finishes task/activity within the time allotted</td>
<td></td>
</tr>
<tr>
<td>Transitions from one activity/setting to another: with in the allowed time</td>
<td></td>
</tr>
<tr>
<td>Transitions from one activity/setting to another: with needed materials and supplies</td>
<td></td>
</tr>
<tr>
<td>Uses free time appropriately (chooses an activity/play mate, plays)</td>
<td></td>
</tr>
<tr>
<td>Participates actively in group activities, projects</td>
<td></td>
</tr>
<tr>
<td>Seeks adult/peer help appropriately</td>
<td></td>
</tr>
<tr>
<td><strong>MOTOR SKILLS</strong></td>
<td><strong>Comments/Adaptations</strong></td>
</tr>
<tr>
<td>------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>Moves through natural and school environment in a safe and timely manner (including emergency evacuations)</td>
<td></td>
</tr>
<tr>
<td>Demonstrates stability at table, on chair, or floor</td>
<td></td>
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<tr>
<td>Participates in learning movement activities similar to peers</td>
<td></td>
</tr>
<tr>
<td>Utilizes all natural and school environments</td>
<td></td>
</tr>
<tr>
<td>Meets personal needs (eating, dressing, toileting) in natural environment or school</td>
<td></td>
</tr>
<tr>
<td>Stabilizes paper while using pencils, crayons, and markers</td>
<td></td>
</tr>
<tr>
<td>Picks up, holds, turns pages of books</td>
<td></td>
</tr>
<tr>
<td>Manipulates play materials (puzzles, blocks)</td>
<td></td>
</tr>
<tr>
<td>Uses school supplies (markers, scissors, eraser, glue, paints)</td>
<td></td>
</tr>
<tr>
<td>Manages backpack</td>
<td></td>
</tr>
<tr>
<td>Stores and retrieves materials in an orderly, timely manner</td>
<td></td>
</tr>
<tr>
<td>Operates standard computer and mouse</td>
<td></td>
</tr>
</tbody>
</table>
What are some of the student's strengths?

Do you have any concerns regarding this student's attendance? yes no
(Including time out of the classroom due to medical procedures)

Is peer acceptance impacted by this student's disability? yes no

Check all accommodations/modifications that you routinely make for this student:

- visual schedule or cues
- assistance or support for transitions
- visual work samples
- alternative keyboard (larger/smaller)
- repeated & simplified directions
- visual work samples
- other
- paraprofessional support
- slant board
- switches
- redirect attention to task
- other
- other
- other

What other issues or concerns do you have for this student?
**ELEMENTARY ORGANIZATIONAL AND INDEPENDENT WORK SKILLS/MOTOR SKILLS CHECKLIST**

**Student's Name:** ___________________________  
**School:** ___________________________  
**Date:** ___________________________

<table>
<thead>
<tr>
<th>ORGANIZATIONAL SKILLS</th>
<th>Comments/Adaptations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follows classroom routines</td>
<td></td>
</tr>
<tr>
<td>Follows classroom rules</td>
<td></td>
</tr>
<tr>
<td>Follows classroom schedules</td>
<td></td>
</tr>
<tr>
<td>Takes notices and appropriate materials home to complete homework</td>
<td></td>
</tr>
<tr>
<td>Transitions from one activity/setting to another: within the allowed time</td>
<td></td>
</tr>
<tr>
<td>Transitions from one activity/setting to another: with needed materials and supplies</td>
<td></td>
</tr>
</tbody>
</table>

**WORK SKILLS**

<table>
<thead>
<tr>
<th>Comments/Adaptations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follows classroom routines</td>
</tr>
<tr>
<td>Follows classroom rules</td>
</tr>
<tr>
<td>Follows classroom schedules</td>
</tr>
<tr>
<td>Takes notices and appropriate materials home to complete homework</td>
</tr>
<tr>
<td>Transitions from one activity/setting to another: within the allowed time</td>
</tr>
<tr>
<td>Transitions from one activity/setting to another: with needed materials and supplies</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Comments/Adaptations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Listens and works without becoming distracted</td>
</tr>
<tr>
<td>Begins work/tasks</td>
</tr>
<tr>
<td>Corrects mistakes and edits work</td>
</tr>
<tr>
<td>Knows when work is complete</td>
</tr>
<tr>
<td>Finishes work/tasks within the time allotted</td>
</tr>
<tr>
<td>Turns work in on time</td>
</tr>
<tr>
<td>Follows verbal directions</td>
</tr>
<tr>
<td>Follows written directions</td>
</tr>
<tr>
<td>Follows multi-step directions in sequence</td>
</tr>
<tr>
<td>Uses free time appropriately</td>
</tr>
<tr>
<td>Participates actively in class discussions, group activities, projects</td>
</tr>
<tr>
<td>Requests help appropriately (teacher, support staff, peer) to clarify classroom requirements or meet personal needs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MOTOR SKILLS</th>
<th>Comments/Adaptations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moves through school environment in a safe and timely manner (including emergency evacuations)</td>
<td></td>
</tr>
<tr>
<td>Demonstrates stability at classroom desk, table, chair, or floor</td>
<td></td>
</tr>
<tr>
<td>Participates in physical education class</td>
<td></td>
</tr>
<tr>
<td>Utilizes all school environments (i.e. lunchroom, locker, bathroom, playground, stage)</td>
<td></td>
</tr>
<tr>
<td>Meets personal needs (eating, dressing, toileting) at school</td>
<td></td>
</tr>
<tr>
<td>Produces handwritten work that is legible and completed within time lines, without fatigue</td>
<td></td>
</tr>
<tr>
<td>Uses school supplies (markers, scissors, eraser, glue, paints)</td>
<td></td>
</tr>
<tr>
<td>Manages books, materials, and back pack</td>
<td></td>
</tr>
<tr>
<td>Stores and retrieves materials in an orderly, timely manner</td>
<td></td>
</tr>
<tr>
<td>Operates standard computer and mouse</td>
<td></td>
</tr>
</tbody>
</table>

**Please complete both sides of this form.**
What are some of the student’s strengths?

Do you have any concerns regarding this student’s behavior? yes no
(including time out of the classroom due to medical procedures)

Does this student get along socially with peers? yes no
Explain further.

Is peer acceptance impacted by this student’s disability? yes no

Check all accommodations/modifications that you routinely make for this student and add as needed:

- visual schedule or cues
- scribing by staff for written responses
- copies of notes
- alternative keyboard (larger/smaller)
- repeated & simplified directions
- visual work samples
- redirect attention to task
- assistance or support for transitions
- tests done in separate area or room
- paraprofessional support
- assignments modified
- portable word processor
- modified tests
- slantboard
- extra time for assignment completion
- other ______________
- other ______________
- other ______________

What other issues or concerns do you have for this student?
**MIDDLE SCHOOL AND HIGH SCHOOL**

**ORGANIZATIONAL AND INDEPENDENT WORK SKILLS/MOTOR SKILLS CHECKLIST**

<table>
<thead>
<tr>
<th>Student’s Name: ____________________</th>
<th>Age: ____________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>School: ___________________________</td>
<td>Setting: __________________</td>
</tr>
<tr>
<td>Date: _____________________________</td>
<td>Completed by: ______________</td>
</tr>
</tbody>
</table>

Curriculum: ___ regular ___ modified ___ alternative

**ORGANIZATIONAL SKILLS**

<table>
<thead>
<tr>
<th>Comments/Adaptations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follows daily class schedule &amp; arrives on time</td>
</tr>
<tr>
<td>Uses and follows assignment book or planner</td>
</tr>
<tr>
<td>Organizes and studies course materials</td>
</tr>
<tr>
<td>Arrives to class/new activity with needed materials and supplies</td>
</tr>
<tr>
<td>Shifts from one classroom activity/setting to another within the allowed time</td>
</tr>
<tr>
<td>Homework is completed &amp; handed in on time</td>
</tr>
<tr>
<td>Does work during class time</td>
</tr>
</tbody>
</table>

**WORK SKILLS**

<table>
<thead>
<tr>
<th>Comments/Adaptations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understands assignment expectations</td>
</tr>
<tr>
<td>Listens and works without distractions</td>
</tr>
<tr>
<td>Begins and completes work/tests within time allowed</td>
</tr>
<tr>
<td>Turns in work on time</td>
</tr>
<tr>
<td>Completes multi-step, long-term projects</td>
</tr>
</tbody>
</table>

*Compare student to others in the class.*

Indicate N/0 (Not Observed) if you have not had the opportunity to observe the behavior in your setting.
| **Obtains and completes makeup assignments when absent** |  |
| Organizes school materials |  |
| Uses independent time appropriately |  |
| Participates actively in class discussions, group activities, projects |  |
| Advocates for self to clarify classroom requirements or meet personal needs |  |

**MOTOR SKILLS** | **Comments/Adaptations**

| Moves through school environment in a safe and timely manner (including emergency evacuations) |  |
| Utilizes all school environments (i.e., lunch room, locker room, stage) |  |
| Participates in physical education class |  |
| Meets personal needs (eating, dressing, toileting) within the daily schedule |  |
| Produces handwritten work (notes and assignments) that are legible and completed within time lines, without fatigue |  |
| Physically manages school materials and belongings in a timely manner |  |
| Organizes folders and locker |  |
What are some of the student's strengths?

Do you have any concerns regarding this student's academic performance? yes no

Do you have any concerns regarding this student's attendance? yes no
(including time out of the classroom due to medical procedures)

Does this student show age appropriate social skills? yes no
Explain further.

Is peer acceptance impacted by this student’s disability? yes no

Check all accommodations/modifications that you routinely make for this student:

- □ visual schedule or cues
- □ scribing by staff for written responses
- □ copies of notes
- □ alternative keyboard (larger/smaller)
- □ repeated & simplified directions
- □ visual work samples
- □ redirect attention to task
- □ slant board
- □ assistance or support for transitions
- □ extra time for assignment completion
- □ paraprofessional support
- □ assignments modified
- □ portable word processor
- □ modified tests
- □ tests done in separate area or room
- □ other ______________
- □ other ______________
- □ other ______________
- □ other ______________

What other issues or concerns do you have for this student?
### ORGANIZATIONAL SKILLS

<table>
<thead>
<tr>
<th><strong>Always/Often</strong></th>
<th><strong>Sometimes</strong></th>
<th><strong>Rarely/Never</strong></th>
<th><strong>Comments/Adaptations</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Follows daily classroom/work schedule</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uses organizational system to record and document changes in class/work schedule, absences, hours worked, planned activities</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Requests/organizes needed supplies for class/work</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Transitions from classroom to work/community settings within allowed time</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transitions from classroom to work/community settings with needed work supplies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-checks to assure work or job completion</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### WORK SKILLS

<table>
<thead>
<tr>
<th><strong>Always/Often</strong></th>
<th><strong>Sometimes</strong></th>
<th><strong>Rarely/Never</strong></th>
<th><strong>Comments/Adaptations</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Understands classroom/vocational expectations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Listens and works without distractions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Completes classroom/vocational tasks or activities on time</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uses independent time appropriately</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calls in when sick; takes responsibility to make up missed tasks as needed</td>
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<td>-----------------------------------------------------------------</td>
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<td></td>
</tr>
<tr>
<td><strong>Adapts to new expectations</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Participates actively in discussions</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Problem solves in vocational/community setting</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Advocates for self to clarify work or skill requirements</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>MOTOR SKILLS</strong></th>
<th>Comments/Adaptations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Moves within classroom/vocational/ community sites in a safe and timely manner</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Demonstrates understanding of and can direct implementation of emergency evacuation plan.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Engages in transition activities requiring active participation (e.g., vocational, post-secondary, recreation/leisure, community, home living)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Meets personal needs (eating, dressing, toileting) within the classroom/work schedule</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Produces written work requirements within the five transition areas within timelines and without fatigue</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Manages/manipulates materials and belongings in a timely manner</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Operates computer, printer and mouse</strong></td>
<td></td>
</tr>
</tbody>
</table>
Do you have any concerns regarding this student's academic performance? yes no

Do you have any concerns regarding this student's attendance? yes no
(including time out of the classroom due to medical procedures)

Does this student show age appropriate social skills? yes no
Explain further.

Is peer acceptance impacted by this student's disability? yes no

Check all accommodations/modifications that you routinely make for this student and add as needed:

- □ visual schedule or cues
- □ paraprofessional support
- □ scribing by staff for written responses
- □ tasks/jobs modified
- □ copies of notes
- □ extra time for task completion
- □ alternative keyboard (larger/smaller)
- □ assistance or support for transitions
- □ repeated & simplified directions
- □ other ______________
- □ visual work samples
- □ other ______________
- □ redirect attention to task
- □ other ______________

What other issues or concerns do you have for this student?
Students with Physical Impairments:
Suggested Protocol for Initial Evaluation Following Hospitalization

Student: _________________________ Date of Birth: ________________________________

School/Grade: ________________________________________________________________

Date of Injury/Hospitalization: __________________________________________________

Type of Injury __________________________________________________________________

Parent Name/Phone #: __________________________________________________________

Collaboration between all involved partners- the hospital, school and family- is critical when a child or youth with a significant physical impairment is transitioning between the hospital or rehabilitation setting, the home, and school. The following protocol, with family involvement and permission, is recommended, as these students typically require accommodations and/or modifications in the educational setting.

A timely return to school is beneficial. Schools can customize a student’s day to ease the transition and accommodate ongoing medical needs such as pain, fatigue, and medication side effects.

● Following Admission to the Hospital

Once a parent or hospital representative has contacted the school district, a school representative (P/HD Teacher, special education case manager, or school nurse) is assigned as the contact person by the administrator. The school representative will:

☐ Contact parent(s) to inquire about their child’s condition and determine how and what information will be shared with school community

☐ Obtain a release of information if one is not in the school file.  
  **Note:** A signed Release of Information form must always be kept in student’s file.

☐ If a recent injury, initiate discussion about the evaluation process

☐ Contact the child’s caseworker at the hospital to:
  • Initiate discussion about the evaluation process
  • Discuss school re-entry issues/questions

☐ Meet with the child’s classroom teacher(s) and education staff to inform them of child’s condition

☐ Obtain and review current educational records to be shared with hospital team
Suggested Protocol for Initial Evaluation Following Hospitalization, continued

• After student’s condition has stabilized, the school representative will contact the hospital case manager to:
  
  ☐ Obtain information regarding the child’s condition
  
  ☐ Determine if/when to send schoolwork

• Prior to discharge from the hospital, the school representative/team will:
  
  ☐ Visit with student and hospital/rehabilitation staff
  
  ☐ Determine need for special education evaluation, and initiate if appropriate
  
  ☐ Obtain copies of current hospital evaluations and documentation of the medical diagnosis of the physical impairment
  
  ☐ Arrange and/or conduct school in-service to:
    • Provide specific information about the student’s condition
    • Provide general information about the physical impairment
    • Discuss potential modifications, i.e., ramp, wheelchair, transportation, ADL support, classroom support
  
  ☐ Contact parent(s) to:
    • Determine when/if the child will be getting post-acute rehabilitative care
    • Establish a date for return to school
  
  ☐ Follow-up with hospital case manager; get updates on discharge plan and needs
  
  ☐ Recent injury: Conclude special education evaluation, determine eligibility, and (if appropriate) develop IEP
  
  ☐ Student with an existing IEP: Modify IEP and accommodations to reflect current needs
  
  ☐ Develop additional plans as needed (Individual Health Plan, Emergency Care Plan, Emergency Evacuation Plan)

• After the first weeks at school, the team will:
  
  ☐ Re-evaluate the student’s needs and modify IEP accordingly
  
  ☐ Maintain collaboration with parents, teacher(s), and medical personnel
Students with Physical Impairments: For Students with Existing IEPs
Following Medical Procedure/Hospitalization

(To be completed by medical staff. Send one copy home with family at discharge and fax copy to child’s school prior to discharge, assuming a release of information has been signed.)

Child’s Name: __________________________ Date: _________________________

Medical Record Number: _______________ Date of Birth: ____________________

This child has been hospitalized from _______ to _______ due to medical procedures related to his/her medical diagnosis. Specific information and recommendations regarding a return to school or a childcare program are documented below.

Follow-up visit or procedure will occur on:

Resume school/childcare program (Check one): ☐ homebound ☐ half day ☐ full day

Duration (Give dates): ________________________________________________
_________________________________________________________________

Changes in medication and possible side-effects to monitor: ____________________

Transportation (Check one):

☐ regular ☐ lift bus ☐ bus seat belt ☐ direct adult supervision

Please specify duration of bus ride permitted and date for possible review: _________
_________________________________________________________________

Physical Education Class (Check one): ________ resume regular class _______ modify

If modified, please list restrictions ________________________________________
_________________________________________________________________

Contact sports (Check one): ______________ resume ________________ modify

If modified, please list restrictions ________________________________________
_________________________________________________________________

Presenting educational problems resulting from medical procedure:
_________________________________________________________________
Please identify restrictions related to weight-bearing and transfers:

_________________________________________________________________

Specific recommendations related to ROM and other stretching activities:

_________________________________________________________________

Specific recommendations related to time in and out of wheelchair:

_________________________________________________________________

If additional information is needed about this child’s return to school or childcare, contact:

Name ________________________________

Phone ________________________________

Email ________________________________
EMERGENCY EVACUATION PLAN TEMPLATE

Student Name: ___________________________ Grade: ____

School Year: _________________________

Case Manager: ________________________

Classroom Teacher/Room Number: ____________________________

Student Description (disability/condition, equipment needs, etc.): ________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

Physical/Safety Issues: ________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

Method of communication:

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

Procedures:

➢ In the event of a fire drill/emergency:

➢ In the event of a severe weather drill/emergency:
EMERGENCY EVACUATION PLAN TEMPLATE, continued

➤ In the event of a tornado drill/emergency:

➤ In the event of a lock-down drill/emergency:

➤ Location and Staff assigned:

➤ Special Considerations:

**Note:** To be filed in current year IEP and/or IHP

**cc:** school administration, all IEP team members, school health services
Sample Job Description
Itinerant Special Education Teachers

Purpose: This job description provides a general listing of the day-to-day activities of itinerant teachers, primarily in the low-incidence disability areas of blind/visually impaired, deaf/hard of hearing, physical health disabilities, and autism.

Many of the items on the list could constitute indirect time for individual student IEPs. This indirect time includes training for general and special education staff when the training is specific to a student.

Activities

1. Attend IEP meetings when IEP manager is not properly licensed in the area of disability, reviews progress, and makes recommendations for changes to the IEP.

2. Plan and conduct regularly scheduled meetings for all teachers (relevant to the role of the itinerant position) in the district (or cooperative) for purposes of staff development and assurance of consistent practice across the district.

3. Provide training to general education teachers about specific disabilities.

4. Provide in milieu training for teachers and paraprofessional in a variety of ways: modeling, team teaching, observation, etc.

5. Provide leadership in service delivery “best practices” for assigned programs.

6. Provide individualized student interventions as needed.

7. Participate in evaluations and re-evaluations as the teacher licensed in the area of disability and who is “knowledgeable about the disability.”

8. Train general and special education teachers and students how to use equipment and specially designed materials.

9. Conduct assistive technology/equipment trials with students to determine what works best for the student and if the equipment is needed.

10. Provide resource materials to parents and teachers about the specific disability and certain methodologies.

11. Conduct in-services for general education teachers about the nature of the disability and specific interventions regarding specific students (i.e., at transition points such entering junior high school).
Itinerant Activities (continued)

12. Provide training for paraprofessionals about general intervention strategies for specific disabilities and help IEP manager develop strategies for monitoring effectiveness.

13. Participate on child study teams, student/teacher assistance teams when it is suspected a child may need to be referred for an evaluation (includes reviewing reports from outside agencies, medical reports, etc.)

14. Work with building teams to set up programs for specific students who are new to the district, transitioning from more restrictive placements, etc.

15. Assist in developing annual staff development plan for special education teachers and paraprofessionals to ensure that the program is continuously improving.

16. Represent the district or cooperative on State and Regional disability-specific committees as appropriate and disseminate information.

Thanks for contributions by the Shakopee Public Schools, Special Services Department (2001)