Guidelines for

Physical Therapy in Educational Settings

Working Draft

State of Connecticut Department of Education—1999

Guidelines for Physical Therapy in Educational Settings

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Foreword

The Connecticut State Department of Education is pleased to provide you with these guidelines in draft publication. They have been designed to:

- promote best practice in physical therapy in educational settings,
- encourage a continuum of service delivery options, and
- provide an overview of the conceptual framework of physical therapy as a support in educational settings.

As stated in the *Connecticut Agenda for Improving Education Services to All Students, Particularly Students Eligible for Special Education and Related Services*, service delivery should emphasize a collaborative approach across disciplines in order to accommodate the needs of each learner. This collaborative approach is emphasized throughout this document.

Physical therapy as an educational support service can be quite different from physical therapy in a hospital or clinic. School-based therapists focus on assisting students to acquire the functional abilities necessary to access educational materials and adapt to their educational environment. They may help students with daily activities related to educational participation, adapt the performance context, teach alternative methods, or facilitate the use of assistive devices. Physical therapists in schools work with other educational professionals, members of the community and families to help all students engage in their educational activities. This collaboration is also the foundation for promoting the participation of students with disabilities in the general educational environment. These guidelines suggest service delivery models that increase the capacity of schools to meet the needs of all children.

Many individuals assisted in the development and review of these guidelines, including school therapists, faculty from Connecticut colleges and universities, administrators, other district personnel and families. We invite you to use these guidelines and provide written comments and suggestions for future improvements.

Theodore S. Sergi
Commissioner of Education

Acknowledgments

Special recognition is extended to the following individuals including occupational therapists and physical therapists for their expertise, time, materials selection, and outlines of key information included in this document. Their professional contributions in reviewing and commenting on the document drafts facilitated the transformation of material into text.

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Appreciation is also extended to the organizations whose publications were used extensively as references.

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This document should be viewed as an evolving set of guidelines. Changes in laws, regulations and practices regarding physical therapy in educational settings may impact its content.

April 1999

SECTION I
Introduction

1. Historical Perspective

Physical therapy and the physical therapist's role in educational settings have evolved along with educational reforms. More recently therapists, school administrators and teachers are searching for service models relevant to educational environments and curriculum. Parents, students, and school personnel seek collaboration, mutual decision-making, and inclusion of students with their peers as much as possible. However, the education and training for physical therapists covers services in many settings such as hospitals, nursing homes and schools. Training includes assisting people of all ages, using diverse therapy approaches.

Traditional school-based therapy often isolated students with disabilities from their peers. Therapists identified "problems" among students and treated them in a special therapy room. Families and teachers often were not encouraged to participate directly in therapy. Interventions were provided to students who had been pulled out from classroom activities. Sometimes the therapy did not correlate with students' everyday environments, or transfer readily to requirements of the school setting. The need for more appropriate education of students, including those with disabilities, spurred legislative changes in the mid 1970s.

Professional research in physical therapy suggests that a collaborative service model works best. Rather than simply pulling students out of classes for interventions that may not apply in classrooms, key professionals and families together identify, evaluate, plan, provide varied service delivery models, and reevaluate how students can best function in various educational settings. Services and evaluation focus on the whole student and the student environment. The entire team involved with the student provides input and strives to offer interventions which support and promote success in students' educational programs and objectives. Physical therapy goals support preparation for learning, living and working. Physical therapy interventions are effective when they improve student performance in contexts in which students participate.

To increase their effectiveness in school environments, as well as to meet increasingly complex federal requirements, the Connecticut State Department of Education produced initial guidelines for physical therapists in 1982. Physical therapy is one of the "related services" of special education under federal and state laws. The original Connecticut guidelines defined physical therapist roles, student physical conditions that might require evaluation, and therapy activities to help students benefit from their special education programs. Since then, federal laws affecting children with disabilities have changed significantly and new laws are in effect. Concurrently, "related services" have developed alternative service delivery models, offering creative activities to meet specific needs of students with disabilities within educational environments.

2. Vision Statement

All people in Connecticut are valued and respected as contributing members of their own family and diverse communities. When physical disabilities compromise or disrupt students' educational performance, physical therapy practitioners provide essential services. Physical therapy practitioners offer individualized, contextualized, culturally relevant educational services by building effective partnerships with students, family members, educators, and other providers representing a broad range of educational, medical and social service disciplines.

The Connecticut Shared Vision and the Connecticut State Board of Education Position Statement on the Education of Students with Disabilities are cornerstones for services physical therapy practitioners offer (see appendices). Physical therapy practitioners and paraprofessionals (where relevant) under their direction:

- adhere to federal and state laws, regulations, policies, and standards;
- provide essential and unique services to students with disabilities and their families. In a supportive role, physical therapists help students participate and learn at school, at home and in the community;
- help families obtain valued life outcomes for students with disabilities. These include choices, meaningful relationships, work, safe home and educational environments, and health;
- deliver an array of services, which change as students develop. Programmatic consultation, teaming, collaboration, and/or direct service may be appropriate at different stages and transitions in the students' lives;
- facilitate inclusion of students in the same natural environments, routines, and activities as their peers through shared responsibility, collaboration, curricular environmental modifications; introduction of specialized equipment; and specific skill development;
- promote interagency collaboration, shared responsibility for service implementation, and coordination of the multiple systems that deliver services and offer support to students and their families; and
- promote hiring an adequate supply of properly trained personnel who pursue appropriate continuing education and other professional development activities.

3. Mission and Purpose

The purpose of these guidelines is to provide a concise, comprehensive reference manual which defines the role of physical therapy as a related service under the Individuals With Disability Education Act (IDEA) and other relevant federal and state regulations. The mission arising from the purpose is:

- to provide an overview of the conceptual framework of physical therapy as an educational component, including:
  - requirements,
  - guiding principles,
  - unique role/responsibilities, and
  - relationship to curriculum involvement.

- to promote awareness of assessment and service delivery patterns;
- to promote a continuum of service delivery options, recognizing collaboration as an essential, fundamental strategy for developing students' functional outcomes within the context of their natural environments;
- to promote best practices; and
- to encourage professional development, peer support and mentoring.

4. Physical Therapy Role in Educational Settings

Physical therapy as an educational support service can be quite different from physical therapy in a clinic or hospital. School-based therapists focus on removing barriers from students' ability to learn, helping students develop skills which increase their independence in the school environment, and educating school personnel about the different considerations required for students with disabilities. Everything the therapist does with students in the school must be educationally relevant. Therapists examine and intervene to improve students' functional abilities in school classrooms, hallways and other areas that may be part of their educational program (i.e., community facilities and vocational settings).

The therapist works with teachers to help students acquire functional abilities necessary to access educational materials and move about the school. To help students function better in classrooms, the lunchroom, or restrooms, therapists may work with them or with school personnel on adapting or modifying their equipment/materials. Other assistance includes helping students participate in activities outside of the school through mobility on field trips, sports events, on playgrounds and within the community.

Special education students face a demanding environment at school. Presentation methods for educational materials must be modified to meet the challenges of students' disabilities, such as their ability to communicate, view and manipulate educational materials, maintain postures, and move about the school. Therapists work closely with teachers to promote the highest level of function possible for students pursuing educational goals.

The following table illustrates how physical therapy services in schools have evolved.

Physical Therapy As An Educational Support Service

Historical Continuum

Formerly	Currently
Focus on Disabilities and Problems	Focus on Student Learning Outcomes and Abilities
Pullout Isolated Service	Support to Student from all School Personnel
Families Given Information, Little Involvement	Families Team with School Personnel as Partners
Students' Segregated from other Students	Students Included with other Students
Therapy-specific Student Goals	Curriculum-based Educational Student Goals
Therapist Provides Service Independently	Many Types of School Personnel Involved
Standardized Tests Used	Also Observe and Assess Student Level of Functioning
Clinic-Based Assistance	School- and Community-Based Assistance

Adapted from: B. Blossom, F. Ford and C. Cruse. Physical Therapy/Occupational Therapy in Public Schools. Vol. II. Rome, GA: Rehabilitation Publications & Therapies, Inc. 1996.

SECTION II

Laws and Regulations

1. Physical Therapy under IDEA

The Individuals with Disabilities Education Act (IDEA) **Part B** and Connecticut General Statutes Sections 10-76a to 10-76dd, inclusive, require special education and related services for children with disabilities ages 3 through 21 “who are diagnosed with a disability, or a combination of disabilities listed in IDEA, and who, because of the disability need special education and related services. Related services are “such developmental, corrective, and other supportive services . . . as required to assist a child with a disability to benefit from special education, and includes ... physical therapy” (34 C.F.R 300.16). Special education means “specially designed instruction” that meets the unique needs of students with disabilities.

A. LRE Continuum. In addition to instruction in the classroom, the special education continuum of services includes instruction at home, in a hospital, and in other institutions.

Special education and related services are part of students’ individualized education programs (IEP), which detail the educational program tailored to meet students’ specific educational needs. The individualized education program (IEP) does not mean the **best** or **maximum** education possible, but should confer educational benefit “likely to produce progress, not trivial education advancement” (Osborne, 1995).

In 1997 Congress reauthorized amendments to IDEA which cover numerous areas, such as: state and local educational agency role and responsibilities, eligibility criteria, student disciplinary situations, private/parochial/charter schools, parental involvement, IEP provisions, data collection, records, and grant funding (see appendices). The full text of IDEA, amendments and other legislation summarized in these *Guidelines* should be referred to whenever needed for decision-making and fuller understanding.

In order for students to receive physical therapy (PT) services under IDEA Part B, the federal law requires that the students be eligible for special education and that the related service be necessary to assist the students with disabilities to benefit from special education. In this manner, PTs serve in a supportive role, helping students participate in and benefit from special education.

Physical therapy is defined as services provided by a qualified physical therapist (34CFR 300.16(9)(7))

B. Eligibility covers children with disabilities in any of the following federal classifications who may have a need for physical therapy as a related service:

- mental retardation;
- hearing impairments, including deafness;
- speech or language impairments;
- visual impairments, including blindness;
- serious emotional disturbance;
- orthopedic impairments;
- autism;
- traumatic brain injury;
- other health impairments;
- specific learning disabilities;
- multiple disabilities;
- neurologic impairment;
- developmental delays (3-5 years).
  (see United States code 20USC)

Eligible students may include at a state's discretion, individuals, ages 3 through 5, who are experiencing developmental delays as defined by the state. Lack of instruction in reading or math, or limited English proficiency, is not a basis for determining disability.

C. Required Services for students with disabilities include a free appropriate public education (FAPE). This means special education and related services provided at public expense, under public supervision and direction, and without charge, which meet the state standards. Preschool, elementary or secondary school education is provided in conformity with the students' IEPs.

Services include:

- special education;
- related services needed by students to benefit from special education means transportation and such developmental, corrective, and other related/supportive services including:
  - speech pathology and audiology,
  - psychological services,
  - physical and occupational therapy,
  - recreation, including therapeutic recreation,
  - social work services,
  - counseling services,
  - medical services (diagnostic or evaluation only),
  - parent training and counseling,
  - assistive technology devices and services,
  - rehabilitation counseling, and
  - school health services.

D. Team models described in IDEA are implemented with multidisciplinary service delivery (see glossary) and focus on students' educational/learning needs. Families are specifically included as members of the team which makes student eligibility, placement and program decisions. The regular education teacher participates in the IEP meeting, when appropriate, to help determine the extent and nature of the students' participation in the general curriculum. In Connecticut such teams are defined as Planning and Placement Teams (PPT).

E. LRE (Least Restrictive Environment) (requirement of service delivery) states that, "to the maximum extent appropriate, children with disabilities are to be educated with children who are not disabled, and that ... removal of these children from the regular educational environment occurs only when the nature or severity of the disability is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily."

F. Continuum of Alternative Placements requires that each public agency ensure a continuum of alternative placements is available to meet special education and related services needs of students with disabilities. The IEP team must determine which of the alternative placements listed in the definition of special education best meets the needs of the student. Alternative placements include instruction in regular classes, special classes, special schools, home instruction, instruction in hospitals and institutions, and services to supplement regular class placement such as resource room or itinerant instruction [34CFR, 300.551 and RSCA, Sec. 10-76d-14].

G. Individualized Educational Program (IEP) is developed for each student receiving special education and related services. A written plan must be in effect at the beginning of each school year and before any special education and related services are provided. The State Department of Education has endorsed a draft uniform IEP form.

The IEP must include:

- a statement of the measurable annual goals and short-term instructional objectives or benchmarks with the relevance to the general curriculum for the students related to (a) meeting the student's needs that result from the student's disability to enable the student to be involved in and progress in the general curriculum and (b) meeting each of the student's other educational needs that result from the disability;

- the specific special education and related services which will advance students goals, including assistive technology services or devices, if appropriate, and physical therapy services only with a doctor's prescription for educationally appropriate services;

- a statement of the specific educational services needed by the student, including a description of special education and related services and the supplementary aids and services to be provided to the student, or on behalf of the student, and a statement of the program modifications or supports for school personnel that will be provided for the student: (a) to advance appropriately toward attaining the annual goals; (b) to be involved and progress in the general curriculum and to participate in extracurricular and other nonacademic activities; and (c) to be

educated and participate in the regular class and in extracurricular and other nonacademic activities;

- a statement of the student's present levels of educational performance, including how the student's disability affects involvement and progress in the general curriculum; or for preschool students, as appropriate, how the disability affects the student's participation in appropriate activities;

- an explanation of the extent, if any, to which the student will not be able to participate with non-disabled students in the regular class and in the extracurricular and other non-academic activities;

- transition planning, as applicable, that includes: (a) beginning at age 14 and updated annually, a statement of the transition service needs of the student under applicable components of the student's IEP that focuses on the student's courses of study (such as participation in advanced-placement courses or a vocational education program); (b) beginning at age 16 (or younger, if determined appropriate by the PPT), a statement of needed transition services for the student, including, when appropriate, a statement of the interagency responsibilities or any needed linkages; and (c) beginning at least one year before the student reaches the age of eighteen, a statement that the student has been informed of his or her rights that will transfer to the student on reaching the age of eighteen;

- the projected date for the beginning of the services and modifications, and anticipated frequency, location, and duration of those services and modifications, including the length of the school day and school year and criteria to determine when services will no longer be needed;

- a statement of how the student's progress toward the annual goals will be measured which is to include objective criteria and evaluation procedures;

- a statement of any individual modifications in the administration of State or districtwide assessment of student achievement that are needed in order for the student to participate in a particular State or districtwide assessment of student achievement (or part of such assessment) a statement of why that assessment is not appropriate for the student; and how the student will be assessed;

- a statement of how the student's parent will be regularly informed which is at least as often as parents are informed of their nondisabled student's progress toward the annual goals, and the extent to which that progress is sufficient to enable the student to achieve the goals by the end of the year;

- a list of individuals who shall implement the IEP; and

- in the case of a residential placement, whether such placement is being recommended because of the need for services other than educational services.

- IEP team participants are a group of individuals comprised of:
- the student, when appropriate;
- at least one special education teacher or special education provider of the student, as appropriate;
- at least one regular education teacher of the student if the student is or might be participating in a regular educational environment;
- a representative of the local education agency (LEA) who is qualified to provide or supervise the provision of specially designed instruction; is knowledgeable about the general curriculum and about the availability or resources of the school district;
- parents or guardians of the student;
- an individual who can interpret the instructional implications of the evaluation results, who may otherwise be a member of the team;
- at the discretion of parents or LEA, other individuals who have knowledge or special expertise regarding the student, including related services personnel, as appropriate;
- in evaluating a student suspected of having a specific learning disability, the student's regular teacher, or, if the student does not have a regular classroom teacher qualified to teach a student of his or her age, at least one qualified person to conduct individual diagnostic examinations of students, such as a school psychologist, speech-language pathologist, or remedial reading teacher.

If the purpose of the PPT is consideration of transition services for a student, the LEA shall invite; (1) the student; and (2) a representative of any other agency that is likely to be responsible for providing or paying for transition services. If the student does not attend, the LEA shall take other steps to ensure that the student's preferences and interests are considered. If an agency invited to send a representative to the PPT does not do so, the district shall take other steps to obtain the participation of the other agency in the planning of any transition services.

In addressing the composition of the PPT, as noted above, the LEA shall include certified and/or licensed professionals, who represent each of the teaching, administrative, and pupil personnel staffs and who participate equally in the decision making process. These persons shall be knowledgeable in the areas necessary to determine and review the appropriate education program for the student. The administrative representative shall be a person, other than the student's teacher, who is qualified to provide or supervise the provision of special education.

The regular education teacher of the student, as a member of the PPT, shall, to the extent appropriate, participate in the development, review and revision of the IEP of the student, including the determination of appropriate positive behavioral interventions and strategies and determination of supplementary aids and services, program modifications, and support for school personnel.

Meetings must be held at least once a year to review each student's IEP and, if appropriate, revise its provisions. **Schools must report to parents on the progress of their children with disabilities at least as frequently as the school reports progress of non-disabled students.** The IEP commits in writing any resources necessary for students with disabilities to receive special education and related services.

H. Transition Services are "a coordinated set of activities for a student, designed within an outcome-oriented process, which promotes movement from school to post-school activities including post-secondary education, vocational training, integrated employment, (including supportive employment), continuing and adult education, adult services, independent living, or community participation" (34 CFR Sec.300.18).

Services must be based on students' needs, taking into account the student's interest and preferences, and include instruction, community experiences, employment and other post-school adult-living objectives development, and if appropriate, acquisition of daily living skills and functional vocational evaluation. Planning for transition services must begin at age 14 with a statement of transition needs in the IEP, such as a prevocational course.

I. Services must be at no cost to parents. The state may use any available federal, state, local, and private sources. Part B of IDEA does not relieve an insurer or other third party from an otherwise valid obligation to provide or pay for services.

J. Parental Rights focus primarily on families being informed and involved. Key provisions are that parents:

- receive written prior notice whenever the school district proposes or refuses to initiate or change the: identification, evaluation, educational placement, or provision of FAPE;
- receive full information in the native language or other mode of communication unless clearly not feasible;
- give informed consent for the: initial evaluation, reevaluation, initial placement in special education, and placement in private school. Consent for evaluation cannot be construed as consent for placement. If parents refuse, the LEA may pursue evaluation or placement through mediation and hearing procedures. In the case of private placements, LEAs must initiate due process if parents refuse consent;
- must have an opportunity to participate in meetings concerning identification, evaluation, placement, and provision of FAPE; however, LEAs may meet without the parents present if the parent has been provided with proper notice;
- may withdraw consent at any time;
- provide consent for release of information under certain circumstances;

- may inspect and review their child’s records (FERPA and confidentiality requirements established in Part B apply) and request amendments to the record, with limitations, which includes a hearing process if the local educational agency (LEA) disagrees with the amendment request;

- must be given a copy of procedural safeguards in easily understandable language. Information about the procedural safeguards must include:
    - independent educational evaluation,
    - written prior notice,
    - parental consent,
    - access to educational records,
    - opportunity to present or file complaints, and request a hearing,
    - student’s placement while awaiting outcome of due process proceedings,
    - procedures for interim alternative education settings,
    - requirements for unilateral placements of their children in private schools at public expense,
    - mediation,
    - due process hearings,
    - state-level appeals (if applicable),
    - civil actions, and
    - possible attorneys’ fees.

- may initiate an impartial due process hearing when the LEA proposes or refuses to initiate or change: identification, evaluation, or educational placement of the student or the provision of a free appropriate public education to the student.

Procedures are in place to protect the rights of students whenever parents/guardian are unknown or students are wards of the state.

K. Evaluation Requirements include an **initial evaluation** to determine whether a student is a student with a disability and to determine educational needs and modifications. Evaluation includes administering tests and other evaluation materials in the student’s native language or other mode of communication unless not feasible. Tests cannot be discriminatory. When standardized tests are used, trained personnel must administer them in conformance with the producer’s instructions. Instruments must be validated for the specific purpose for which they are being used, and assess the specific areas of educational need. No one procedure shall be the sole criterion for determining an appropriate educational program. Evaluations must be designed by a multidisciplinary team, including at least one teacher or specialist with knowledge about the suspected disability. In Connecticut, the planning and placement team designs the evaluation.

Students should be assessed in all areas related to the suspected disabilities. Local Educational Agencies (LEAs) shall ensure reevaluation if conditions warrant, or if parents or the child's teacher request it, at least once every 3 years (triennial evaluation). The purpose of re-evaluation is to determine the child's continuing eligibility for services. Parents must provide consent for reevaluation. However, if the district can show that it had taken reasonable measures to obtain consent and the parent fails to respond, consent is not needed. If parents disagree with the local school district evaluation, they have the right to an independent educational evaluation at public expense, which the LEA can contest through a hearing. If a hearing officer orders an independent evaluation, such evaluation is at public expense.

L. Placement should be based on information from a variety of sources, documenting and considering all data sources. Placement must be reviewed annually. A group of persons including persons knowledgeable about the student, the meaning of the evaluation data, and the placement options should make placement decisions. In Connecticut, the PPT makes this decision.

M. Assistive Technology Services and Devices as defined by IDEA are: selecting, acquiring, and training to use "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 children with disabilities." Specific activities could include:

- evaluation of needs including functional evaluations in the students' customary environment;
- purchasing, leasing, or otherwise acquiring assistive technology devices;
- selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;
- coordinating and using other services with assistive devices;
- training or technical assistance for students or, when appropriate, families; and
- training or technical assistance for professionals.

2. Other Federal Laws that Affect the Delivery of Physical Therapy in School Settings

A. Section 504 of The Rehabilitation Act of 1973, Title V (Public Law 93-112), and **Title II of the Americans With Disabilities Act (ADA)**, Public Law 101-336, both can have major implications for physical therapists in school systems. Section 504 of the Rehabilitation Act is a broad civil rights law, which protects the rights of individuals with disabilities in programs, and activities that receive federal financial assistance from the U.S. Department of Education.

Section 504 requires an accommodation plan for all students who meet the definition of disabled. General education is responsible for providing equal access to all programs operated by the public school to students with disabilities under the requirements of Section 504. Sometimes students with disabilities are not eligible for special education services yet have difficulty participating in and benefiting from educational programs.

The physical therapist can have varying roles in meeting the needs of students who qualify for services under Section 504 or the ADA, including:

- providing assistance in environmental adaptations;
- acquiring or modifying equipment or devices;
- helping develop the written educational accommodation plan;
- participating in the determination of 504 eligibility.

Any school that receives federal funds must modify or make substitutions in meals for students whose disabilities restrict their diet, such as providing blended foods, special diets, cafeteria modifications, or utensils, at no extra cost.

The Americans with Disabilities Act of 1990 (ADA) is a civil rights law with a clear and comprehensive national mandate to eliminate discrimination against individuals with disabilities. Under Section 504 of the Rehabilitation Act and Title II of the ADA, students might be eligible for physical therapy services as a reasonable accommodation to help them learn, care for themselves, perform manual tasks, walk, speak and breathe.. Under Section 504, any student who is currently disabled cannot be denied, or excluded from, educational services. The definition of disability in Section 504 and the ADA is much broader than the disability categories specified in IDEA. Section 504 identifies individuals with disabilities if they have a physical or mental impairment which substantially limits a major life activity, have a record of the impairment, or are regarded as having such an impairment. Students with disabilities defined under 504/ADA must have equal access to educational services of equivalent quality as nondisabled students.

B. Head Start Act of 1964 provides comprehensive health, education, dental and social services to infants, toddlers, and preschoolers whose families meet economic guidelines. At least 10 percent of enrollment in Head Start can be used for preschoolers with disabilities, including those with developmental delays (latter if the state so chooses). The PT role is to provide services to students as identified in an IEP in the least restrictive environment (Public Law 103-252).

C. Goals 2000: Educate America Act is an educational reform law which lists eight national education goals. Schools must strive to help *all* students, including those with disabilities, to reach challenging academic and occupational standards. The Act includes goals, which refer to PTs contribution to students' and families' learning and the PTs professional development (Public Law 103-227).

D. School-To-Work Opportunities Act of 1994 is a joint effort of the U.S. Department of Education and Department of Labor to establish a national framework for states to create "transition" systems. It intends to integrate academic and occupational learning so that students find productive and rewarding roles in the workplace. The PT may be asked to help students make transitions to adult/worker roles (P.L. 103-239).

E. Title XIX of the Social Security Act of 1965 (Medicaid) provides state funding for medical, social, psychological and health services to individuals and families meeting income-based criteria. Services include early and periodic screening, diagnosis, and intervention for students under age 21. The PT may become involved in billing Medicaid. However its focus on medically-oriented therapy goals, rather than educational goals, could create confusion in completing Medicaid forms for reimbursement of PT services. Medicaid coverage should not cause school-based physical therapy to become a medically based model.

F. Confidentiality Laws, which protect personal information on education records (including health records), include: IDEA, the Family Educational Rights and Privacy Act (FERPA) and state statutes. Parents have the right including, but not limited, to:

- inspect and review the contents of all records concerning identification, evaluation, placement and FAPE provision;
- request that the school district amend the record's information if the parent believes that the information is inaccurate, misleading, or violates the privacy rights of their child;
- know who besides the parents and authorized school personnel has access to information in the records.

Further information on confidentiality regulations for student records is in Section VI, Part D, Documentation of these *Guidelines.*

3. Connecticut Professional Licensing

Requirements Regulations, professional standards, and practice acts for related service personnel are covered in Section VI. Documentation these *Guidelines* (also see appendices).

In summary, laws regarding physical therapy in educational settings assure students' ability to participate in the educational program. Laws do not include provisions to reduce underlying medical impairments, unless it is feasible and clearly improves access and participation in education. Typically, adaptations and modifications in the educational environment are made.

SECTION III
Collaboration

1. Collaborative Systems

Collaboration systems are practices to achieve a style for interaction between at least two co-equal parties voluntarily engaged in shared information, expertise and decision-making as they work toward a common goal.

The *Position Statement on Educating Students with Disabilities*, adopted by the Connecticut Department of Education in June 1996, states that good practice requires … a collaborative approach to service delivery that includes parental involvement, use of community-based resources, learning experiences that are both school-based and work-based, and pupil services and supports (psychology, guidance, counseling, social work, speech and language and health services).” (See Appendix)

For physical therapists (PTs) to be effective in the school setting, they should develop and use collaboration skills to promote inclusion of students with disabilities into the general educational environment with their peers. Working as a team heightens awareness and knowledge of individual team members, thereby increasing collaboration opportunities. Since physical therapy services can only be provided with a doctor’s prescription, the physician is a crucial member of the collaboration team. The doctor should be apprised of ongoing educational planning. Conditions conducive to collaboration include:

- mutual goals;
- parity among participants, all input equally valued;
- shared accountability for students’ progress;
- shared resources;
- voluntary participation.

Under the right conditions, a collaborative style can exist in any school decision making process or activity. PTs, parents and other professionals plan together and make decisions, which help students and families to successfully participate in the school and community. Bringing their expertise into the collaborative environment, PTs and other professionals assume that all perspectives are valid and valued, thereby fostering creative problem solving.

Successful collaboration of PTs working in schools necessitates administrative support and understanding of the:

- time PTs need for collaboration with general and special education teachers, other related services providers, and families;
- strategies to promote collaboration and deal with resistance;
- ways to alleviate barriers to collaboration between PTs, educators, other professionals, and parents.

2. Collaborative Teams in the Educational Environment

Collaborative teams use the unique viewpoints of each team member to produce integrated plans for students and families. Plans may include implementation strategies, modifications to classroom activities or curriculum, or decisions on appropriate assessments. Team members communicate via formal and informal systems such as: regular team meetings, communication notebooks, and action plans designating persons responsible for specified actions by specified dates. Structuring and recording collaboration meetings reinforces the concept's importance. (See sample meeting form at the end of this Section III.)

Team approaches can be transdisciplinary, multidisciplinary or interdisciplinary; all involve a group of individuals from various professions working together on behalf of students.

- Multidisciplinary teams require minimal collaboration. Team members are responsible for common students or purposes, but use their skills and knowledge independently, periodically informing other team members.
- Interdisciplinary teams require significant collaboration. Members use their skills and knowledge to work together on common purposes. They plan, coordinate, and deliver services collaboratively.
- Transdisciplinary teams require maximum collaboration. Members share expertise, skills and knowledge with each other, and share roles when working together on common students or purposes. They plan collaboratively, train one another, and deliver services by sharing roles and responsibilities.

Physical therapists undertake collaborative roles on a variety of teams:

A. Educational Teams address the needs of students. Teachers, physical therapists, occupational therapists, physicians, nurses, adaptive PE teachers, paraprofessionals, and parents/guardians together design a shared vision of and for students. They collaborate on: planning assessment (evaluation) and services (type and delivery); designating responsible persons, selecting outcome measurements, and establishing timetables.

B. Curriculum Teams can be system-wide, consisting of professionals (generally teachers) responsible for curriculum design and implementation. Physical therapists may be involved at the curriculum design stage. Physical education (PE) teachers; adaptive PE teachers; health education teachers; teachers in music, art and computers; and nurses collaborate on these teams concerning:

- disability awareness issues;
- health maintenance and fitness promotion for all students including students with special health needs;
- health screening advisement including fitness testing and scoliosis screenings;
- learning styles from a developmental, sensory-motor and visual-motor perspective.

C. Health Maintenance Teams are responsible for promoting healthy lifestyles and health maintenance. PTs may collaborate with PE teachers, occupational therapists, physicians, nurses, and health teachers to:

- encourage physical activity for all students including those with disabilities and those in special education;
- promote fitness and healthy lifestyles;
- identify risk factors for unhealthy living;
- offer fitness testing;
- assist in prevention screenings such as scoliosis screenings;
- instruct in body mechanics/lifting procedures.

Physical therapists are required to have a doctor's prescription before providing educationally appropriate services. Teams need to consult with the prescribing doctor to develop appropriate goals.

D. School Management Teams address classroom and common room designs and layouts. Physical therapists collaborate with administrative, and building & grounds staff concerning accessibility issues such as:

- Americans with Disabilities Act (ADA) interpretation and implications;
- structural barriers in school and community learning settings;
- designing space that promotes access for all in common areas such as cafeteria, gym, music and art rooms, library, bathrooms, outdoor spaces, and playgrounds;
- transportation issues;
- fire drill planning.

E. Administrative Teams consist of school administrators and special education and pupil services directors. Physical therapists collaborate with the administration team to:

- establish minimum competencies for related services staff;
- provide critical current information on licensure and supervisory standards within their profession;
- set standards of best physical therapy practice;
- interpret and implement the ADA;
- identify legal issues;
- communicate guidelines for paraprofessional employment;
- identify efficient use of limited resources.

F. Family Teams include parents/guardians, supporting:

- using adaptive equipment at home;
- minimizing architectural barriers;
- home programs/carryover;
- planning transitions to adult life.

3. Collaboration with School Nurses and Physicians

In order to accomplish effective health care interventions for students, communication among all providers of care within the school setting is critical. Related services professionals have complementary areas of expertise and need to collaborate in order to provide efficient and effective student services. It is particularly important that physical therapists plan time in their schedules to consult with the building's school nurse regarding students whom they serve and to communicate regularly regarding students with underlying health conditions. This can be accomplished through team meetings, the use of written input sheets or memos, and planned conferencing. They also need to consult and collaborate with the school medical advisor and students' physicians, as appropriate, in planning, providing and evaluating health-related services for students with actual and potential health problems.

Transdisciplinary teaming is based on the concept that the multiple needs of a student are interrelated and sometimes most effectively delivered by more than one or two providers. Such teaming requires cross-disciplinary sharing of expertise and, at times, role release, wherein information and skills of one professional are transferred to a professional in another discipline (or "delegated," if the skills are not within the scope of practice of the second professional). Interdisciplinary and transdisciplinary collaboration and teaming, and use of the school nurse as the school-based coordinator of student health care services, will contribute to improved accountability of all related service personnel and safer, enhanced services for students.

School nurse responsibilities include the provision of safe environments for all students. To accomplish this, school nurses must maintain an active and collaborative relationship with all school professionals, including other related service providers. School nurses are integral members of the educational team, attend child-study team meetings and, as appropriate, PPTs to provide comprehensive health assessment information, collaborate with related service personnel in writing health-related IEP objectives, and facilitate the optimal wellness of students. School nurses are responsible to assess students to identify health and developmental concerns and health care needs in school, and to plan care, including technological procedures and emergency care interventions appropriate for implementation within the school setting. They are also responsible to refer students to physicians and other team members, as appropriate, for additional assessment, preventive strategies, diagnosis and intervention.

School nurses are licensed to diagnose student responses to actual and potential health problems. Based on their assessment of student needs, they develop Individualized Health Care Plans (IHCP) for students with special health care needs in school. The assessment and IHCP are completed in collaboration with the family, community-based health care providers and school personnel, including occupational and physical therapists and speech and language pathologists. Students' plans should reflect collaboration among all appropriate team members and coordination of services in order to effectively and efficiently meet their special needs. The Connecticut Department of Education's *Specialized Health Care Procedure Manual for School Nurses** defines the IHCP as a "detailed and orderly program of action designed to monitor, prevent, manage, reduce, or eliminate identified health problems in order to maintain or improve the student's learning, independence and positive coping."

When it is either required by licensure of the related service professional or appropriate to meet the needs of the student, physical therapists and other related services professionals must consult with the appropriate medical providers of the student. This should

be done, as much as possible, in collaboration with the school nurse and other school health professionals who are serving the student.

* *Specialized Health Care Procedure Manual for School Nurses* (Connecticut Department of Education, 1997). Also see *Serving Students with Special Health Care Needs* (Connecticut Department of Education, 1992).

4. Training

Physical therapists should have opportunities to obtain training in effective teaming and collaboration skills. Through the federal Integrated Related Services Grant, administered by the Special Education Resource Center (SERC), The State Department of Education encourages institutions of higher education to offer quality pre-service preparation programs for PT students interested in pursuing a pediatric specialty. PT degree programs should include content on educationally based therapeutic services and collaborative roles, as well as traditional service delivery. Teachers, particularly new staff and teaching assistants, should be trained to ensure they understand the collaborative relationship between therapists, educators, teaching assistants, and families.

An effective PT training program should develop PT students' ability to:

- recognize overlapping areas of expertise, then select the best provider(s) for the students' or families' program;
- participate in role release and share professional competencies with other team members to facilitate multiple skill opportunities/experiences in natural environments;
- implement innovative methods based on students' and families' individualized needs;
- communicate clearly and effectively in oral and written form, and interact by using mutually understood vocabularies and procedures;
- understand the various stages/phases of the collaborative process;
- exhibit caring, respectful, empathetic, and open attitudes during teaming interactions;
- gather information effectively; elicit and share information; explore problems and set goals, objectives, benchmarks, and action plans;
- recognize and acknowledge others' ideas and accomplishments;
- manage potential conflict and confrontation, to facilitate and maintain collaborative relationships;
- manage time required for the collaborative process so that the needs of all students and the team are met;
- access and use a variety of data collection measures for problem identification and clarification, goal achievement, and accountability;
- recognize and support administration needs; and
- empower families and students to fully participate as team members.

5. Practices to Achieve Collaboration

Although IDEA does not mandate service coordination, PTs recognize collaboration as best practice. Therapists in a position of initiating collaboration in a school system may wish to use strategies such as:

- initially focusing energies on teachers, therapists and paraprofessionals who are eager to collaborate;
- using these successful relationships as a model to include others;
- having a group focus such as team evaluation; and
- noting that team building is a process — starting small.

The following lists detail competencies for which professionals should strive.

10 Golden Rules of Collaborative Consulting

1. Find common ground.
2. Treat each other with complete respect.
3. Don't pose as an expert.
4. Ask questions.
5. Build on strengths.
6. Do what you say you are going to do.
7. Maintain confidentiality.
8. Listen — really listen.
9. Value relationships over efficiency.
10. Provide positive feedback.

Characteristics Desirable in Team Members are:

- strong professional identity;
- excellent communication skills;
- flexibility;
- respect for cultural diversity;
- respect for other professions;
- respect for role of parents as partners;
- ability to role release appropriately, including knowledge of when to release and when not to release; and
- knowledge of and ability to carry out many different models of service delivery.

The list on the next page, adapted from West and Cannon (1998), is useful as a self-evaluation checklist or in professional development activities.

Collaborative Consultation Competencies

1. Demonstrate knowledge of various stages/phases of the consultation process.
2. Assume joint responsibility for identifying each stage of the consultation process and adjusting behavior accordingly.
3. Match consultation approach(es) to specific consultation situation(s), setting(s), and need(s).
4. Practice reciprocity of roles between consultant and consultee in facilitating the consultation process.
5. Translate relevant consultation research findings into effective school-based consultation practice.
6. Exhibit ability to be caring, respectful, empathic, congruent, and open in consultation interactions.
7. Establish and maintain rapport with all persons involved in the consultation process, in both formal and informal interactions.
8. Identify and implement appropriate responses to the stage of professional development of all persons involved in the consultation process.
9. Maintain positive self-concept and enthusiastic attitude throughout the consultation process.
10. Demonstrate willingness to learn from others throughout the consultation process.
11. Facilitate progress in consultation situations by managing personal stress, maintaining calm in time of crisis, taking risks, and remaining flexible and resilient.
12. Respect divergent points of view, acknowledging the right to hold different views and to act in accordance with convictions.
13. Communicate clearly and effectively in oral and written form.
14. Utilize active ongoing listening and responding skills to facilitate the consultation process (e.g., acknowledging, paraphrasing, reflecting, clarifying, elaborating, and summarizing).
15. Determine own and others' willingness to enter consultative relationship.
16. Adjust consultation approach to the learning stage of individuals involved in the consultation process.
17. Exhibit ability to grasp and validate overt/covert meaning and affect in communications (perspective).
18. Interpret nonverbal communications of self and others (e.g., eye contact, body language, personal boundaries in space) in appropriate context.
19. Interview effectively to elicit and share information, explore problems, set goals and objectives.
20. Pursue issues with appropriate persistence once they arise in consultation process.
21. Give and solicit continuous feedback, which is specific, immediate and objective.
22. Give credit to others for their ideas and accomplishments.
23. Manage conflict and confrontation skillfully throughout the consultation process to maintain collaborative relationships.
24. Manage timing of consultation activities to facilitate mutual decision making at each stage of the consultation process.
25. Apply the principle of positive reinforcement to one another in the collaborative team situation.
26. Be willing and safe enough to say "I don't know...let's find out."
27. Recognize that successful and lasting solutions require commonality of goals and collaboration throughout all phases of the problem-solving process.

28. Develop a variety of data collection techniques for problem identification and clarification.
29. Generate viable alternatives through brainstorming techniques characterized by active listening, non-judgmental responding, and appropriate reframing.
30. Evaluate alternatives to anticipate possible consequences, narrow and combine choices, and assign priorities.
31. Integrate solutions into a flexible, feasible, and easily implemented plan of action relevant to all persons affected by the problem.
32. Adopt a "pilot problem-solving" attitude, recognizing that adjustments to the plan of action are to be expected.
33. Remain available throughout implementation for support, modeling, and/or assistance in modification.
34. Redesign, maintain, or discontinue interventions using database evaluation.
35. Utilize observation, feedback, and interviewing skills to increase objectivity and mutuality throughout the problem solving process.
36. Develop role as a change agent (e.g., implementing strategies for gaining support, overcoming resistance).
37. Identify benefits and negative effects, which could result from change efforts.
38. Facilitate equal learning opportunities by showing respect for individual differences in physical appearance, race, sex, handicap, ethnicity, religion, socioeconomic status, or ability.
39. Advocate for services, which accommodate the educational, social, and vocational needs of all students, including those with and without disabilities.
40. Encourage implementation of laws and regulations designed to provide appropriate education for all students with disabilities.
41. Utilize principles of the least restrictive environment in all decisions regarding students with disabilities.
42. Modify myths, beliefs, and attitudes, which impede successful social and educational integration of students with disabilities into the least restrictive environment.
43. Recognize, respect, and respond appropriately to the effects of personal values, belief systems of self and others in the consultation process.
44. Ensure that persons involved in planning and implementing the consultation process are also involved in its evaluation.
45. Evaluate the impact of input, process, and outcome variables on desired consultation outcomes.
46. Engage in self-evaluation of strengths and weaknesses to modify personal behaviors influencing the consultation process.
47. Utilize continuous evaluative feedback to maintain, revise, or terminate consultation activities.

Adapted from: J. Fredrick West and Glenna S. Cannon, "Essential Collaborative Consultation Competencies for Regular and Special Educators", *Journal of Learning Disabilities*, January 1988.

Collaboration Team Meeting Worksheet

Persons Present: *(Note late arrivals)* Absentees: Others Who Need to Know:

Roles:	This Meeting	Next Meeting
Timekeeper:		
Recorder:		
Equalizer:		
Other:		
Other:		

Agenda

Items Minutes Time Limit

1. Positive Comments:
2.
3.
4.
5. Processing (task & relationship):
6.
7.
8.
9. Processing (task & relationship):

Minutes of Outcomes

Action Items: Person(s) Responsible

10. Communicate outcomes to absent member and others who need to know by
11.
12.
13.
14.

Agenda Building for Next Meeting

Date: Time: Location:

Expected Agenda Items:

1.
2.
3.
4.

[sample for consideration]

1. Referral

IDEA and the Connecticut General Statutes mandate that the local education agency (LEA) identify, locate and evaluate all students in their jurisdiction who have disabilities and need special education and related services. The IEP team may refer students to physical therapy services who demonstrate dysfunction in areas affecting educational participation, such as:

- posture and positioning;
- range of motion;
- equilibrium and protective reactions;
- manipulative skills;
- mobility;
- muscular and cardiopulmonary systems strength.

Since referral procedures vary among school systems, therapists should become thoroughly familiar with the process in their assigned school(s). Many schools have an established referral protocol, which may include data collection and introducing alternate educational interventions so that unnecessary referrals can be avoided altogether. This process is sometimes called "pre-referral" and examines work samples, preferred strategies, and problem-solving strategies. Collaboration remains the foundation for procedure development and implementation. School staff members or parents may initiate referrals in the educational setting. Assessment priorities should focus on the referral concern or complaint. Parents should be included in development and implementation of all aspects: alternate educational interventions, referral strategies, evaluation and intervention. The latter might include: providing equipment and/or strategies for teachers to enhance student performance, and limited direct intervention. Federal law requires that the LEA obtain informed parental consent before conducting an evaluation. Further, consent for evaluation cannot be assumed as consent for placement.

When a physician prescribes physical therapy services, a determination would then need to be made whether the prescription is for educational or medical services. Federal (IDEA) mandates are that school-based PT services must be educationally related. In addition, Section 504 indicates that as teams determine appropriate accommodations for children to access programs, they may need to call upon the physical therapist to provide services. (A sample referral form is in Section V. Intervention of these *Guidelines*.)

For best practice in referrals, physical therapists should:

- assume responsibility for determining the appropriateness of the scope, frequency and duration of services within the parameters of the law;
- suggest other appropriate resources to the IEP team when therapists determine that the knowledge and expertise of other professionals are indicated;
- educate current and potential referral sources about the process of initiating physical therapy referrals.

Intended to facilitate student learning in regular educational settings, alternate educational interventions are introduced and documented. Sometimes called *prereferral*, the intent is to support regular education teachers. LEAs are legally required to document

prereferral, and provide strategies or adaptations to regular education settings before initiating a referral for student evaluation. Sometimes teachers can make simple changes in classroom environments rather than going through a relatively complex referral to the IEP team, which would result in the same change. (Sample checklist on following pages includes considerations for both physical and occupational therapy.)

2. Assessment

In medical clinics, physical therapists (PTs) typically assess their clients' impairments, which might influence movement behavior, such as pain, muscle strength, endurance, etc. Treatment objectives focus on reducing impairments and improving function. In schools, physical therapists identify impairments and functional limitations, which interfere with students' ability to participate fully in the educational program.

School PTs use evaluation results to:

- instruct teachers how to avoid risks for students;
- inform parents about problems which must be monitored;
- establish baseline data for comparative measurements at the end of the IEP term.

School PTs assess students' functional performance during the school day, rather than conduct "impairment specific" examinations. School therapy intends to help students and teachers compensate for and accommodate students' impairments so that students can participate in school as much as possible.

Assessment within the educational setting is a continuous process where the physical therapist works in collaboration with the team to:

a) determine eligibility for service within students' natural environment;
b) establish baselines for documenting progress, and
c) help plan intervention strategies.

An important objective of the assessment/evaluation process is to re-clarify the presenting problem by integrating information from a combination of assessments related to function, environment and curriculum.

School PTs use basic information from assessments to:

- document impairments and their degree of severity;
- document students' functional performance level at school;
- modify students' positioning, and methods of functional performance and mobility;
- modify the environment to compensate for, or accommodate, existing impairments;
- instruct parents, students and teachers about precautions that students with disabilities need to take at school;
- advise parents about what they can do at home to maintain or promote educational performance of their children, including incorporating equipment, positioning, and exercise into family routines and activities;
- establish a line of communication with therapists and physicians who are seeing the student in a medical clinic;

- coordinate with the multiple agencies serving children with disabilities and their families.

[sample for consideration]

Classroom Adaptations to be Considered for Common Related Service Referral Complaints (*Prior to Comprehensive Assessment)*	
Referral Complaint	**Possible Adaptations**
Poor lunch skills/behaviors	Provide a wheeled cart to carry lunch tray Provide large handled utensils Clamp lunch tray to table to avoid slipping Serve milk in sealed cup with straw
Poor toileting skills	Provide a smaller toilet Provide looser clothing Provide a setup stool for toilet/sink
Can't stay in seat; fidgety	Allow student to lie on floor to work Allow student to stand to work Provide lateral support to hips or trunk (e.g. rolled towels) Adjust seat to correct height for work Be sure feet are flat on floor when seated Provide more variety in seatwork
Clumsy in classroom/halls; gets lost in building	Move classroom furniture to edges of room Send student to new locations when halls are less crowded Provide visual cues in hall to mark locations Match student with partner for transitions
Can't get on or off bus independently	Allow student to back down stairs Provide additional smaller steps
Can't get jacket/coat on/off	Place in front of student, in same orientation each time Provide larger size for easier handling
Drops materials; can't manipulate books, etc.	Place tabs on book pages for turning Provide small containers for items Place all items for one task on a lunch tray
Poor attention, hyperactive, distractible	Decrease availability of distracting stimuli (e.g. visual or auditory) Provide touch cues only when student in prepared for it Touch student with firm pressure Provide frequent breaks in seatwork
Poor pencil/crayon use	Use triangle grip on pencil/crayon Use fatter writing utensil Provide larger sheets of paper Provide paper without lines

	Provide paper with wider-spaced lines
Poor cutting skills	Provide adapted scissors Provide stabilized paper (e.g. tape it down, use large clips, c-clamps)
Unable to complete seatwork successfully	Provide larger spaces for answers Give smaller amounts of work Put less items per page Give more time to complete task Change level of difficulty
Loses personal belongings; unorganized	Make a map showing where items belong Collect all belongings and hand them out at the beginning of each activity
Doesn't follow directions	Provide written or picture directions for reference Provide cassette tape of directions Allow student to watch a partner for cues

From: Dunn, W. *Pediatric Occupational Therapy: Facilitating Effective Service Provision.* Thorofare, NJ:Slack, 1991. Used with permission.

Given the IDEA requirement to educate children in the least restrictive environment, therapists should assess how students function in classrooms, the cafeteria, halls, playgrounds, restrooms, bus, and any other relevant setting within the school environment. Assessments may occur in community environments when transitioning students from school to adult life.

The physical therapist's assessment has two initial purposes:

1. to help determine which students have disabilities needing special education and related services;
2. to contribute baseline information for developing intervention goals and objectives, and assessing progress.

Therefore, the information should support a decision of eligibility, and provide data that the IEP meeting participants can use to identify present performance levels and priority areas requiring intervention.

Examples of screening, assessment, and clinical observation tools and strategies follow. These tools are best used to analyze *why* students are having functional difficulties in educational settings - not to establish interventions. Low student scores on standardized tests do not necessarily imply need for service, nor are PTs required to use any particular test. However IDEA requires that the planning and placement team "not use any single procedure as the sole criterion for determining" whether students have a disability or what interventions students need. "No single procedure is used as the sole criterion for determining an appropriate educational program for a child."(34 C.F.R. 300.532 (d)). Functional assessments are best practice in school settings (see three sample functional performance checklists at the end of this section).

School Functional Assessment (SFA) — is a judgment-based questionnaire rating typical performance on a range of school-related tasks and activities. The SFA includes criterion-referenced scales to measure meaningful functional change.

Impairment Scale — Five-point rating scale of gross sensory and motor function, by the American Spinal Injury Association.

Child Health Assessment Questionnaire — four-point level of difficulty rating for resting, standing, walking, eating, hygiene, grip and release.

Feasibility Assessment Wheelchair and BIPED Ambulation — criterion checklist of effectiveness, efficiency and safety of ambulation/mobility.

Steinbroker Classification for Rheumatoid Arthritis — four-point functional capacity rating scale.

Vignos Functional Rating Scales — identifies performance levels from I ambulation to maximal dependence.

Gross Motor Function Measure — functional limitations of lying, rolling, sitting, kneeling, crawling, standing, walking, running and jumping.

COMPS — clinical observations of motor and postural skills for children ages five to nine.

Spinal Mobility — compares normative spinal mobility data regarding anterior and lateral flexion (S. Haley).

GARS — gait assessment rating scale covers 16 items rated 0-3.

(Additional tests to consider are listed in the appendices.)

Physical therapists should take an active role in helping school personnel determine when children need physical therapy assessments. This may necessitate team discussions, informal screening/observation, and in-services for staff. Therapists and teachers should develop written criteria for:

1) teachers' initial observations of students' behavior;
2) strategies teachers employ to address students' needs; and
3) reasons teachers should question whether students need physical therapy.

3. Evaluation

The evaluation process should be collaborative, multidimensional, and relevant to the specific concerns or questions that were raised, and provide a reliable and valid baseline for decision making. After reviewing referral information, the evaluation team should select its performance focus — areas, components and contexts. The data should create a profile of strengths and concerns, which can be used to:

- identify conditions that limit performance; and
- formulate an efficient intervention strategy.

Based on the American Physical Therapy Association (APTA) "Standards of Practice", the PT "performs and documents an initial examination and evaluates the data to identify problems and determine the diagnosis prior to intervention". School systems often elect to conduct a screening to determine if a full evaluation is appropriate. Further, APTA standards state: "the physical therapist examination:

- "is documented, dated and appropriately authenticated by the physical therapist who performed it.
- identifies the physical therapy needs of the patient or client.
- incorporates appropriate tests and measures to facilitate outcome measurement.
- produces data that are sufficient to allow evaluation, diagnosis, prognosis and the establishment of a plan of care.
- may result in recommendations for additional services to meet the needs of the patient or client."

IDEA requires that assessment procedures take into account students' age, developmental level, gender, education, socioeconomic, cultural and ethnic background, medical status and functional abilities. Best practice recommends that the evaluation include some combination of skilled observation, interview, record or work sample review, or standardized or criterion-referenced evaluations.

Students in vocational programs will have a number of different educational goals, implying variation in education-related skills being assessed. While PTs may be responsible for an evaluation, a Physical Therapy Assistant (PTA) may contribute to it under PT supervision. Evaluation timeframes should also reflect federal and state requirements. Federal requirements under IDEA are on the following page.

Evaluation Procedures under IDEA '97

1. Personnel administer non-discriminatory tests and other evaluation materials that are selected and administered so as not to be discriminatory on a racial or cultural basis; and are provided and administered in the student's native language or mode of communication unless it is clearly not possible.
2. Trained and knowledgeable personnel ensure that any standardized tests that are given to the student have been validated for the specific purpose for which they are used and are administered in accordance with any instructions provided by the producer of such tests.
3. No one procedure is the sole criterion for determining whether a student meets the eligibility criteria for special education or determining an appropriate educational program for the student. The results of standardized or local tests of ability, aptitude, affect, achievement and aspiration shall not be exclusively used as the basis for placement.
4. Use a variety of assessment tools and strategies to gather relevant functional and developmental information, including information provided by the parents to assist in determining whether the student meets the criteria for special education and the content of the student's IEP, including information related to enabling the student to be involved in and progress in the general curriculum or, for preschool children, to participate in appropriate activities.
5. Use of technically sound instruments that may assess the relative contribution of cognitive and behavioral factors, in addition to physical or developmental factors.
6. The student is assessed in all areas of suspected disability.
7. Assessment tools and strategies that provide relevant information that directly assist persons in determining the educational needs of the student.

Educational functioning should be the primary focus of an evaluation; services should consider modifications and adaptations to the environment. Considerations and status factors affecting an evaluation are:

Considerations:

- student age;
- disability (type, degree, complications);
- academic status (placement, change);
- previous physical therapy (rate of change);
- other assessment and intervention results;
- previous IEP goals and objectives;
- school program opportunities;
- parent/family involvement;
- continuum of service options in school and community; and
- other.

Status Factors:

- post-hospitalization for neurological or orthopedic reasons;
- equipment breakdown;
- equipment needs;
- pre- or post-medical evaluations;
- response to parental or staff concerns;
- other significant priority; and
- transition between programs/schools.

4. Reevaluation

Federal regulations require reevaluation of students receiving related services "every three years or more frequently if conditions warrant, or if the child's parent or teacher requests an evaluation" (IDEA '97). The Planning and Placement Team (PPT) is responsible for determining types of assessments based on the PPT's need for information about students in order to make continuing eligibility, program and placement decisions. PTs should become familiar with the school system's method of informing therapists about triennial due dates.

While the areas evaluated and evaluation instruments can differ from those used for preplacement evaluation, re-evaluation procedures must meet the same legal requirements. Sometimes each school professional on the team conducts a separate triennial evaluation; sometimes they do so as a team. Giving parents a copy of the report prior to the individualized education plan (IEP) meeting affords them an opportunity to identify areas needing clarification.

5. Entry and Exit Criteria

If the school district has not developed entry and exit criteria, the Planning and Placement Team should collaboratively establish criteria based on student performance areas, measurable IEP goals, and objectives. All team members including regular education, special education, related services personnel, administrators, and parents should be involved.

The recommended practice for entrance criteria should include:

- problem significantly interferes with students' ability to participate in their educational programs;
- problem appears to be caused by limitations in physical therapy performance component(s);
- previous attempts to alleviate the problem through alternate educational interventions have not been successful;
- potential for change in students' problems through intervention appears likely (change unrelated to maturity);
- physician authorization;
- unique expertise of therapist is required to meet students' identified needs.

The recommended practice for exit criteria are:

- goals or outcomes requiring therapy have been met and no additional goals are appropriate;
- potential for further change from therapy service appears unlikely;
- problem ceases to be educationally relevant;
- physician decertification; and
- therapy is contraindicated due to medical, psychological or social complications.

6. Assessment Types

Practitioners should become very familiar with any assessment tool before using results as an important factor in determining the reason for disability or the service need. Also, clinical observations within the scope of practice are essential components of an interdisciplinary assessment. Student functional performance during the school day is a crucial area of assessment. (See sample functional assessment forms at the end of this section.)

Functional areas include:

1) school bus: move on and off, sit;
2) hallways: move through, carry items;
3) classroom: move about on floor, position for floor activities, position for activities in a chair, position for activities while standing, transfer activities, move in a wheelchair, walk;
4) restroom: sit, stand, transfer, access hygiene items; and
5) cafeteria: view food display, reach, carry, and feed, dispose of tray.

Therapists should be aware of the major categories of assessment tools and their applicability/value in school therapy:

A. Ecological/Environment Inventories evaluate students within a variety of educational environments, to analyze tasks that environment requires. Other professionals involved in students' growth and development contribute clinical observations and information/inventories to help determine requirements in the students' natural environment. Clinical observations could include: range of motion, reflexes, muscle tone, and sensation.

Ecological inventories should consider:

- environmental demands and opportunities;
- curricular expectations;
- tools/instruments to help gather relevant information;
- whether the team needs expansion to obtain needed information.

B. Criterion-Referenced Tests help identify why students have functional difficulties in school, not eligibility for service. They compare students' performance to a previously established criterion rather than to other students from a normative sampling. One example is the "Hawaii Early Learning Profile". Play-based inventories are sometimes criterion referenced tests, for example the "Transdisciplinary Play-Based Assessment" by Toni Linder, and the School Functional Assessment by the Psychological Corporation.

C. Standardized Tests or norm-referenced tests use normative data for scoring, which may include performance norms by age, gender, ethnic group, geographic region, and socioeconomic status. Examples include: "Peabody Developmental Motor Scales", Bruininks-Oseretsky Test of Motor Proficiency", and "Pediatric Evaluation of Disability Inventory".

For scores of standardized tests to be considered valid, PTs must follow the specified protocol when using standardized tests. If the students' disabilities prevent PTs from testing according to standard procedures, the results must clearly indicate this. If standardized tests are not appropriate, results shall be expressed in descriptive reports without using standardized scales. In addition to the (above) tests, examples of standardized tests school PTs may choose to use are: (also see appendices)

Battelle Developmental Inventory
DeGang-Berk Test of Sensory Integration (1983)
Hughes Basic Gross Motor Assessment (1975)
Test of Motor Impairment (TOMI) by Stott-Moyes-Henerson (revised 1984)
Gubbay Tests of Motor Proficiency (1975)
Pediatric Evaluation of Disability Inventory (Haley et al, 1989)
Functional Independence Measure for Children (WeeAM) (Granger et al, 1988).
School Function Assessment (SFA) (Coster et al, 1998).

7. Assessment in School Settings

The school physical therapist is responsible for identifying motor function abnormalities, joint mobility limitations and other neurophysiologic dysfunction, insofar as they **prevent students from participating in educational activities.** Other deficits which concern PTs but which are unrelated to students' ability to participate in educational activities should be documented in the report. Referrals to other professionals should be discussed and directed through the appropriate team.

Situational based functional evaluations identify *what* the difficulty is and *where* it occurs. Criterion referenced and standardized tests are tools to help therapists identify underlying causes and extent of the functional difficulties. Test scores clarify needs rather than imply entry or exit criteria. Based on functional goal needs, students' histories, functional evaluations, and testing, therapists can recommend remediation methods, teach compensatory strategies or suggest adaptations to students' environments. Students qualify for in-school physical therapy services if they demonstrate difficulty accessing educational environments or materials. Individual needs may vary from year to year depending on educational program type and location.

The following sample forms can be helpful in identifying student needs and the least restrictive environment for their education.

Functional Performance Assessment - Teachers

Student: ______________________ Age: __________________ Date: ____________

School: ____________________________ Teacher: ___________________________

*For each question below, place a check on the appropriate line. If the student performs the task but takes too much time, place an * under "yes".*

	YES	NO	N/A	Teacher's Comments on Student's Problems
Classroom/Library/Art				
Can position at all work stations	____	____	____	________________
Can access all work material	____	____	____	________________
Can move between all work stations	____	____	____	________________
Doors				
Can open and close all doors	____	____	____	________________
Can move through doorways	____	____	____	________________
Hallways				
Can travel required distance	____	____	____	________________
Can move through crowded hallway	____	____	____	________________
Can use water fountain	____	____	____	________________
Lunchroom				
Is safe on slippery floor	____	____	____	________________
Can go through lunch line	____	____	____	________________
Can carry lunch tray	____	____	____	________________
Can maneuver in tight space	____	____	____	________________
Can sit at lunch table	____	____	____	________________
Restroom				
Is safe on wet floor	____	____	____	________________
Can move in and out of toilet stall	____	____	____	________________
Can sit or stand at toilet	____	____	____	________________
Can access faucet, soap and towels	____	____	____	________________
School Bus				
Can move on and off bus	____	____	____	________________
Can sit securely on the bus	____	____	____	________________
Playground				
Can access playground	____	____	____	________________
Can play on outdoor equipment	____	____	____	________________
Can negotiate stairs or ramps	____	____	____	________________
Assemblies/Sports Events				
Can access assembly room/gym	____	____	____	________________
Can access athletic field	____	____	____	________________
Can sit with peers	____	____	____	________________
Community Activities				
Can access transit systems:				
cars	____	____	____	________________
buses/vans	____	____	____	________________
trains	____	____	____	________________
Can access buildings	____	____	____	________________
Can access goods and products	____	____	____	________________
Can push grocery cart	____	____	____	________________
Can carry purchases	____	____	____	________________

Additional Requests

Teacher would like more information and instruction about the student's:

wheelchair	____	____	____	______________________
walker	____	____	____	______________________
crutches	____	____	____	______________________
orthosis	____	____	____	______________________
Teacher would like more information about positioning the student.	____	____	____	______________________
Teacher would like assistance with adapting educational materials.	____	____	____	______________________

____

Teacher's Signature

[sample for consideration]

Functional Performance Assessment
Student Needing Assistance

Student: ______________________ Date: ______________________

Indicate a Y for yes and N for no on the line beside each question below.

Comments

1) The student participates in:
   - a self-contained class ____ ______________________
   - a resource class ____ ______________________
   - a mainstream class ____ ______________________
   - an inclusion class ____ ______________________

2) Is there a *safe* and accessible means of moving the student:
   - from the classroom ____ ______________________
   - from the school building ____ ______________________
   - to a designated evacuation area ____ ______________________

3) Are there other barriers inside the school ____ ______________________
   or on the grounds? ______________________

4) Are there any community activities in which
   this student is unable to participate? ____ ______________________

Teacher's Request for Additional Information: *(Place a check beside the item.)*

Student's:
- wheelchair ____ ______________________
- walker ____ ______________________
- crutches ____ ______________________
- orthoses ____ ______________________

Positioning the student ____ ______________________

Adapting educational materials ____

Other: ______________________

Name of therapist ______________________

Name of teacher: ______________________

Adapted from: Blossom, B., P. T. Ford, and C. Cruse. *Physical Therapy/Occupational Therapy in Public Schools, Volume II.* Rome, GA: Rehabilitation Publications & Therapies, Inc. 1996. Used with permission.

[sample for consideration]

Functional Performance Assessment
Student Needing Assistance
Physical Therapy Screening

Student: ________________________________ Date: ______________________

The teacher should place a checkmark beside each item in which the student consistently requires physical assistance from one or more classroom personnel throughout the school day.

Task:	**Needs Help**
SCHOOL BUS:	
moving on and off the bus	____
sitting on the bus	____
HALLWAYS:	
moving in hallways	____
carrying items	____
CLASSROOM:	
moving about on the floor	____
positioning for activities on the floor	____
positioning for activities while sitting	____
moving in a wheelchair	____
transferring from:	
chair to floor	____
floor to chair	____
chair to wheelchair	____
wheelchair to chair	____
walker/crutches to chair	____
chair to walker/crutches	____
positioning for standing activities	____
walking	____
RESTROOM:	
sitting on the toilet	____
getting on/off the toilet	____
standing at toilet/urinal	____
moving to and from changing table	____
accessing sink, soap, towels, mirror	____
CAFETERIA:	
viewing food display	____
reaching and obtaining food	____
carrying food	____
feeding self	____
positioning for eating	____
disposing of tray/utensils/waste	____

Adapted from: Blossom, B., F. Ford, and C. Cruse, *Physical Therapy/Occupational Therapy in Public Schools, Volume II.* Rome, GA: Rehabilitation Publications & Therapies, Inc. 1996.

[sample for consideration]

SECTION V
Intervention

1. Physical Therapist's Role

Physical therapy (PT) can help students with disabilities resulting from prenatal causes, birth trauma, illness, or injury. Intervention can:

- reduce the functional impact of the disability;
- prevent secondary problems (e.g., contractions);
- prevent or minimize impairments, functional limitations and disabilities which interfere with participation in educational activities;
- relieve pain which may occur during educational activities;
- develop and improve motor function needed in school;
- control postural deviations;
- establish/maintain educationally related performance within students' physical capabilities.

In an educational setting, PT services enable students to benefit from special and/or regular education in the least restrictive environment. PT services develop and maintain the students' physical potential for independence in all educationally related activities. PTs also collaborate with regular and special education teachers, physical education teachers, maintenance personnel and others to modify and adapt the student's physical environment, enabling participation in the educational process to the fullest extent possible. The practice act under Connecticut statutes requires physical therapists to obtain a written or verbal referral from a licensed physician before commencing direct interventions. Based on APTA guidelines, intervention in all settings includes three major elements:

1. coordination, communication and documentation;
2. patient/client (i.e. student)-related instruction; and
3. direct intervention.

PT modalities differ in school settings versus hospitals/clinics. In clinical and hospital facilities, PTs may use electrical stimulation, ultrasound, paraffin baths, hot packs and whirlpool, in addition to therapeutic exercise and functional training. School therapy emphasizes collaborative styles of evaluating, preventing and addressing motor impairments, which impact upon students' functional movement in school. Exercise and conditioning to improve students' gross motor function, positioning and movement during educational activities, as well as instruction to staff who assist the students, are common approaches.

School-based physical therapy interventions may consist of motor skill practice and adapting or modifying curriculum, equipment or expectations for students. For example, a PT could help the physical education teacher modify warm-up activities and equipment in a weight training class. Or the PT could focus on underlying components of movements such as increasing flexibility of trunk, shoulder and pelvic areas to enhance stair-climbing ability.

Preventive treatment could be used to teach joint protection skills to students with juvenile rheumatoid arthritis. Students with muscular dystrophy may need range of motion exercises or positioning programs to maintain physical status and movement capacity. Prevention emphasizes long-term benefits over short-term convenience. For example the students with hyper-extended (locked) knees may wish to stand at a lab table. However, if this could damage joint structure, a modified table is better.

School physical therapists:

- document impairments and their severity;
- document students' functional performance level at school;
- modify students' positioning, methods of functional performance, and mobility;
- modify the environment to compensate for or accommodate existing impairments;
- instruct parents, students, and teachers about precautions students with disabilities should take at school;
- advise teachers on how they can incorporate equipment, positioning and exercise to promote students' educational performance;
- advise parents how (at home) they can use equipment, positioning and exercise to maintain or promote their students' educational performance; and
- establish lines of communication with physicians and therapists who are treating students in the wider health care arena where students receive health and medical services.

Physical therapists offer collaborative, student-related services including:

- direct service in small groups or individually;
- staff training and family education concerning activities and strategies to help achieve individualized education program (IEP) goals;
- periodic consultation to staff, students, and parents concerning IEP goals;
- monitoring progress with PT-related IEP goals;
- maximizing safe and effective access and movement in school environments.

2. Direct and Indirect Services

Through *direct and indirect services*, physical therapists use remediation, prevention and compensation. With *direct* therapy, PTs interact directly with students in small groups or one-on-one. Best practice to promote the least restrictive environment is direct physical therapy, which develops a specific skill, phasing therapy out when students can incorporate it into daily routines. Direct therapy should be considered when:

- the physical therapist is the only person who can safely provide a necessary intervention;
- the PT has particular skills or judgment necessary for ongoing intervention and assessment;
- the team decides that alternatives to direct therapy would be unsafe or ineffective.

Indirect physical therapy, often called consultation, occurs when PTs use their knowledge and skills to help students without direct interaction between the two. Through collaboration with educational professionals or paraprofessionals, PTs enable someone other than themselves to implement specific activities. However, since the physical therapist had ultimate responsibility for the children's PT programs, there is always an element of direct contact with the children in an indirect service model.

Through *indirect* intervention, PTs collaborate with teachers or other school staff to help students:

- practice and integrate newly acquired skills;
- incorporate positioning and movement techniques into classroom routines;
- use adaptive equipment with staff and family assistance; and
- use transportation safely to and from school and on school related trips.

Physical therapists educate staff about specific motor diagnoses and their impact upon school activities. The practice act under Connecticut statutes requires physical therapists to obtain written or verbal referral from a licensed physician before commencing direct interventions. A sample form to request referral follows.

PTs may provide *direct* service which enables students to participate fully in school, such as:

- facilitating movement and sensorimotor skills development;
- instructing students in compensatory strategies;
- providing an opportunity for motor learning and skill acquisition;
- designing exercises or activities to remediate motoric deficits; and
- measuring for adaptive equipment.

Request for Physician's Referral for Physical Therapy at School

Student: ______________________________ Date: ______________ DOB: ________

Dear Dr. ______________________________
(physician name)

I am giving you permission to release information about my child to the below-designated representative of the school.

PT Name: ______________________________

Contact Information: ______________________________

____

The Individualized Educational Program (IEP) for my child includes physical therapy services to be carried out in the school. The goal and planned schedule of physical therapy programming is outlined below. We appreciate your cooperation in providing any precautions or contraindications to programming in physical therapy. Your signature is required by the State of Connecticut for referral to physical therapy.

Thank you,

Parent/guardian signature: ____________________ ______________
(date)

Functional Goal (s)

____

____

____

____

Frequency

____

____

____

____

Physician's comments *(please include medical information important for the education team to consider):*

____

____

____

____

Physician's signature: ____________________ ______________
(date)

Adapted from: B. Blossom, F. Ford and C. Cruse. *Physical Therapy/Occupational Therapy in Public Schools, Volume II.* Rome, GA: Rehabilitation Publications & Therapies, Inc. 1996. Used with permission.

[sample for consideration]

3. Individualized Educational Program (IEP)

The annual goals of the IEP identify physical therapy functional outcomes in age-appropriate terms. IEP meeting participants collaboratively define measurable annual goals and short-term objectives or benchmarks, and physical therapy interventions, which help attain the goals. They take into account the:

- students' abilities, age and learning styles;
- deficits or impairments to function;
- environmental demands;
- interventions other team members can provide.

The IEP should clearly define direct and indirect PT services, based on the goals and factors such as:

- complexity of the students' needs;
- number of staff involved;
- support to staff implementing goals related to physical therapy issues;
- level of community involvement;
- need for contact with the medical community;
- nature of modifications in regular education program; and
- nature and priorities of the students' special education program.

4. Service Delivery Plan

The physical therapist derives a service delivery plan in collaboration with others, based on evaluation results and expected outcomes of the student's IEP. The service delivery plan becomes a tool to ensure synchronization with special education and other related services. It varies depending on the most appropriate service delivery model and intervention strategies selected. (See "Focus of PT Services to Enhance Educational Performance" table in this Section V. Intervention.)

Three primary reasons for physical therapy are:

- remediation: establishes or restores students' skills or performance components;
- prevention: reduces students' physical deterioration or emotional distress;
- compensation: develops task activity performance by teaching alternative methods, altering the task, adapting the performance context, or using assistive devices.

The service delivery plan should include information such as:

- name, birth date and diagnosis including prior treatment which could impact upon physical therapy;
- any contraindications or precautions;
- current information on functional abilities, motor skills and physical status;
- IEP goals and short-term objectives/benchmarks for which the PT is totally or partially responsible;
- physical therapy goals and objectives of IEP and how progress will be measured;
- age-appropriate proposed intervention techniques;
- time requirements;
- schedule;
- progress notes.

The delivery site should be flexible depending on needs. The IEP team selects sites (classroom, other school environment, or community) based on criteria such as:

- appropriateness of activity in classroom setting;
- distractibility of the students;
- activity or skill involved;
- student's learning level in a particular skill;
- student's learning style;
- potential disruption by others;
- opportunity for modeling to educate classroom staff;
- teachers' receptivity to integrating activities into classroom.

5. Performance Areas

School physical therapists have primary responsibility to students with disabilities in three general service areas. (See sample forms for considerations on the following pages.)

A. Improving Gross Motor Function. Predicting students' mobility in school is a collaborative decision involving parents, health care providers and the PT, taking into account the:

- medical diagnosis. For example, students with spinal cord injuries and spina bifida vary by the injury level; walking ability decreases over time for students with muscular dystrophy;
- safety issues, especially in crowded hallways;
- energy expended vs. needed for academic activities;
- environment such as distance between classes and stairs;
- time available to move between school activities/locations;
- age appropriateness;
- cumulative trauma to joints and other structures which walking may cause;
- how options (e.g. wheelchair vs. walking) limit or help student participation.

B. Positioning and Facilitating Movement is appropriate for students unable to move or safely stabilize their body during educational activities. Short-term physical concerns may result from a change in medical status such as post-operative handling of students with disabilities. After establishing effective methods of positioning, the PT collaborates with educational staff, training them to:

- facilitate achievement of educational objectives by enhancing movement, providing necessary support or stabilization for movement, or positioning students;
- ensure a variety of position options for students to prevent joint movement limitation and skin breakdown; promote postural stability;
- encourage students to participate in transfers, movement between environments, and positioning.

C. Health and Safety objectives may include interventions to:

- improve physical endurance while participating in school activities;
- minimize contractures and deformities;
- maintain skeletal and skin integrity;
- provide postural drainage through positioning;
- improve respiratory function through positioning;
- minimize present and future musculoskeletal pain experienced during educational instruction;
- support safe entry to and exit from school rooms and buildings;
- support access to school transportation (bus, van).

Through activities such as gait training, motor planning, wheelchair mobility and bus seating training, PTs help ensure safe movement throughout school environments. PTs should also provide input concerning fire drill procedures and other emergency situations to ensure safe, expedient exit from buildings.

Focus of PT Services to Enhance Educational Performance

Posture and Positioning:

- body alignment
- functional use of hands
- stable postural base

Range of Motion (ROM):

- prevent deformities affecting use of the extremities

Enhancement of Motor Experiences:

- includes equilibrium and protective reactions
- muscle tone
- motor planning
- integration of tactile, visual, auditory, proprioceptive, kinesthetic and vestibular input
- bilateral coordination
- motor skills which help organize attention and behavior

Manipulative Skills and Hand/Eye Coordination:

- increasing speed, accuracy and strength in manipulative skills
- using adapted materials for hand-eye coordination

Mobility:

- ambulation
- transfer skills
- wheelchair evaluation and training

Cardiopulmonary Systems:

- increase endurance and tolerance via body mechanics and energy conservation techniques

Evaluation of Supports and Environment:

- evaluate and adapt devices, equipment, materials and seating
- evaluate skin care, splints, bracing
- evaluate architectural barriers and recommend modifications

Training/Educating:

- prepare students for optimal independence in school and future vocation
- train and educate students, families and school staff re. disability and its educational impact
- instruct school staff in body mechanics and handling techniques
- act as liaison between medical and educational professionals

Reference: *Guidelines for Physical Therapy Practice in Educational Environments of Washington State.* Olympia, WA: Washington State Physical Therapy Association, 1991. Used with permission.

[Sample for consideration]

Components for Physical Therapy Evaluation and Intervention

PTs would evaluate many of these and other related components in the context of students' educational needs. PTs assess physical and motor characteristics which impact learning, to help identify needed equipment, accommodations, adaptations and modifications.

Musculoskeletal and Neuromotor Characteristics

_______ muscle tone
_______ muscle strength
_______reflexes
_______ stability
_______ range of motion/flexibility
_______ postural and skeletal status
_______ ability to process and use sensory information
_______ motor learning style
_______ balance and coordination
_______ changing and maintaining positions
_______ strength and endurance
_______ motor planning ability

Functional Capabilities

_______ functional gross motor skills in a developmental context
_______ independent methods of mobility (roll, crawl, scoot)
_______ ambulation
_______ wheelchair use
_______ transfers
_______ spontaneous movement in the natural environment
_______ movement between activities and environments (stairs, ramps, and curbs) changes in terrain, different buildings)
_______ use of adaptive equipment
_______ community mobility
_______ transportation (driver's education, public transportation)
_______ transportation to/from school; field trips
_______ fire drills/emergency exit plans
_______ access to outdoor play equipment

Respiration

_______ breathing patterns (tension, rate, effort, effects of different positions, nose versus mouth)
_______ coughing effectiveness
_______ effect of respiratory status on tolerance for physical activity
_______ need for postural drainage or chest percussion

Special Equipment, Adaptations, Environmental Modifications

_______ environmental adaptations (accessibility, room and furniture modifications)
_______ alternative positioning devices
_______ equipment or environmental adaptations to enhance interactions (manipulation, self-care, switches, communication)
_______ instruction or information to/from parents, teachers, or children regarding equipment needs and modification
_______ seat/desk height in all classrooms

Adapted from: *Occupational Therapy and Physical Therapy: A Resource and Planning Guide.* Madison, WI: Wisconsin Department of Public Instruction, 1996. Used with permission. [Sample for consideration]

6. Eligibility of Injured Students or Post-Operative Students

Students with acute injuries which may affect access to buildings, rooms or vehicles for short, defined periods of time cannot receive direct physical therapy services unless they:

- meet IDEA eligibility requirements;
- have physical therapy needs which are educationally related;
- have an IEP in place before intervention commences;
- have a 504 plan in place;
- have a doctors prescription.

Minor motor problems, which do not interfere with education such as non-progressive scoliosis, poor posture, "knock-knees" and occasional toe walking, would also not receive PT intervention unless they meet the above criteria. School administrators may seek the PTs expertise to accommodate students with temporary needs related to access, mobility and positioning.

7. Communication

Communication is an important school physical therapist function. In the collaborative spirit, PTs help bridge connections between educational and medical communities, explaining the school's services, environment, and legal responsibility to provide educationally supportive physical therapy services. The PT interprets medical information for the school, incorporating medical recommendations relevant to the IEP, and communicates changes in students' physical status, which may require medical intervention. Often PTs collaborate with school nursing personnel responsible for meeting students' special health care needs.

To help instill self-advocacy skills, PTs teach students to talk to vendors, community therapists and physicians about equipment. PTs can also guide students on how to talk to peers about disabilities, advocate, and decide for themselves how much help they need.

It is vital to sincerely listen and prioritize needs in collaboration with parents and school personnel, being open to adjusting IEP goals. Communication with parents should receive high priority; frequent communication increases parent satisfaction with services. Good communication is particularly supportive for students who need physical therapy at an early age because of a congenital disability, that may result in developmental restrictions at some point along the continuum. Since the students' social and emotional growth and independence are as important as motor function, PTs need to help family members with their important supportive role. It is difficult emotionally for students who reach a developmental plateau to focus on independence rather than on developmental progress.

8. Summary

Through direct and indirect services, school physical therapists improve students' educational success. PTs base interventions on both their professional assessments as well as the team's findings. IEP goals and benchmarks provide the framework for interventions, which also must meet professional practice standards and state licensing criteria. Interventions are dynamic, responding to students, staff and family, communication needs, and teaching strategies taking place in classrooms, on field trips and in the community.

SECTION IV
Documentation

In addition to meeting federal and state requirements, documentation is an important communication tool between schools and families. All professionals involved should collaborate to document at least quarterly; and **provide reports as often as is done for students without disabilities.** Therapists should keep current on documentation guidelines for the profession, as well as special school-based requirements.

In general, physical therapists (PTs) upon the completion of the administration of tests and other evaluation materials should:

- write a report of the interdisciplinary or PT evaluation conducted which could contain contraindications to therapy;
- provide information and recommendations for students' IEPs;
- write service plans for students, considering disability and medical diagnosis, contraindications to therapy;
- help develop IEP goals and determine the equipment and personnel/assistance needed to meet the therapy goals;
- write a report when students discontinue therapy.

IDEA does not specify how long therapists must keep documentation. Connecticut has a retention schedule for public records (available from LEAs) which covers education records LEAs maintain. Medicaid or other third party payers may require documentation be maintained for six (6) years. *See Medicaid regulations.*

1. IEP Documentation

The Individualized Education Program (IEP) must document the physical therapy services to be provided to the student. See Section II 1.G. Individualized Education Program.

2. Service Process Documentation

In traditional hospital/clinic settings, a unit of service is typically fifteen minutes. Based on the number of service units provided, total intervention time varies. In school settings with transdisciplinary or interdisciplinary programs, some PT consultative interventions may be very modest, such as a few minutes weekly or monthly. School policies for record keeping should reasonably reflect the PT scope of service, and cost/benefits of extensive documentation.

Documentation in the following areas is recommended:

1. **referral:** initial referral including reason, options considered, regular education interventions, why options rejected. RCSA (Sec. 10-76d-7) requires that the school district make available a standard referral form which shall be used in all referrals.
2. **permissions:** parents' or guardians' written permission for assessment and evaluation, reevaluation, and initial provision for special education services; notice to parents concerning reevaluation.
3. **test protocol data and summary report:** screenings, evaluations, reassessments, IEPs, annual (periodic) reviews and exit results.
4. **intervention:** regular documentation of students' physical therapy interventions. In addition to evaluation reports and treatment plans, documentation for school physical therapy usually includes:
   - attendance records: the amount and frequency of service provided students;
   - progress notes on services plan and data collection on IEP objectives;
   - contacts with vendors and recommendations;
   - contacts with parents;
   - contacts with physicians and recommendations;
   - contacts with teachers and recommendations;
   - discontinuance reports;
   - any additional records Medicaid or other third party payers require.

3. Parental Involvement

Local educational agencies are responsible for facilitating parental involvement. PTs, as part of the IEP team, should assist in documenting activities/actions related to Parental Rights provisions of IDEA (see parental rights, Section II "Laws and Regulations").

Examples of items to document are:

- notice(s) to parents;
- parental consents/withdrawal of consent;
- dates copies of procedural safeguards were provided to parents; and
- procedures to protect rights of students who are wards of the state.

Parent surveys as a component of school district follow-up can help document how physical therapy services reflect the spirit of IDEA. Useful information surveys could elicit include:

- perceptions concerning the number and types of services available to families;
- percentage of families who participate in each service available;
- families' satisfaction with service availability and quality; and
- quality and quantity of families' interaction with PT staff.

Logs of contacts, communication notebooks, notes of parent participation in conferences, and/or parental-signed progress reports are examples of ways to document parental involvement.

Therapists should keep in mind that records may be used in mediation and hearing

procedures. Thus it is useful to ensure documentation includes data useful to mediators and hearing officers.

4. Confidentiality Laws and Student Records

Confidentiality laws protect personal information on education records, which includes health records. Examples are: IDEA, the Family Educational Rights and Privacy Act (FERPA) and state statutes. Therapists in school settings should comply with confidentiality standards required by their profession, and by school district policy. Each local educational agency typically requires certain documentation procedures relevant to consent for sharing information.

A comprehensive system for consistent organization and management of records throughout the school district will facilitate case management, program development, coordination and evaluation, and administrative and legal accountability. The system should include records on students receiving physical therapy and on the overall program. PTs should be aware of the federal and state laws and regulations which address classification, accessibility, review, challenges, amendments, transfer, maintenance and destruction of student records), such as:

- Family Educational Rights and Privacy Act of 1974 (FERPA);
- FERPA incorporated into IDEA at legislation for children with disabilities:
  20 U.S.C Sec 1415(b)(1)(A)
  34 CFR, 300.500, 300.502, 300.560, 300.574
- RCSA Sec 10-76d-18;
- Connecticut Public Records Retention/Disposition Schedule;
- Regulations concerning Medicaid requirements.

FERPA defines records, files, documents and other materials containing information directly related to students and maintained by an educational agency or institution, or by individuals acting for that agency or institution, as “education records” (20 U.S.C., Sec 1232g(4)(A). This includes therapy evaluation reports, progress and conference reports, treatment plans, test protocols and therapy materials and any additional records school districts maintain to support Medicaid payments for services under IDEA - whether stored on paper, audio/videotape or computer. Some third-party records (i.e. from outside agencies or service providers) are not relevant in their entirety; a summary may be transferred to the students’ educational records.

Sole possession records that are not available for review by parents, may be made by instructional, supervisory and administrative personnel, and educational personnel ancillary to them, and are not revealed to anyone other than a temporary substitute. Personal notes or anecdotal comments are sole possession records as long as they remain the sole possession of the therapist. When these records are shared, even verbally, they become subject to all FERPA access and review procedures. Anecdotal comments on test forms or therapy materials are educational records.

Therapists working in schools should be aware of legal requirements for confidentiality of school records:

Rationale

A positive atmosphere of cooperation and trust between parents and local school districts is contingent upon protecting parents' rights to privacy, limiting access to personally identifiable information and fully implementing *policies and procedures* related to confidentiality. *Parents* must be confident that they have control over decisions and information regarding their child.

Required Practices

1. Each board of education shall maintain records concerning children requiring special education and related services and shall provide for the filing, protection, confidentiality, classification, review, and when appropriate, destruction of such records (Sec. 10-76d-18).
2. Each board of education shall have policies and procedures to ensure the confidentiality of education records. All such policies and procedures shall be consistent with the requirements of pertinent state and federal law and regulation (Sec. 10-76d-18(a)) and (Sec. 10-76d-18(a)(1)).
3. All such policies and procedures shall be in writing and shall be made known at least annually to parents of children requiring special education and related services and shall be available to the public (Sec. 10-76d-18(a)(2)).
4. Policies and procedures shall include those relating to securing parental consent (Sec. 10-76d-18(a)(3)).
5. Policies and procedures shall include those relating to amendment of information in education records at a parent's request, where the board of education agrees to amend such information (Sec. 10-76d-18(a)(4)).
6. Policies and procedures shall include those relating to the opportunity for a hearing at which parents may challenge the information in education records (Sec. 10-76d-18(a)(5)).
7. Policies and procedures shall include those relating to safeguards to protect the confidentiality of personally identifiable information at collection, storage, disclosure and destruction stages. This shall also include a record of access to all education records. (Sec. 10-76d-18(a)(6)).
8. Parents shall have the right to inspect and review any education records relating to their child which are collected, maintained or used by the board of education (Sec. 10-76d-18(b)).

Source: State of Connecticut Board of Education, "Requirements and Guidelines for Special Education and Related Services for Children (Ages 3-5) With Disabilities", 1991. page 30. These requirements also apply to children 5 through 21 as cited in IDEA.

SECTION VII
Administration

1. School Practice

Neither the state statutes regulating physical therapy practice in Connecticut nor the American Physical Therapy Association Standards of Practice address practice in specific settings such as schools. Instead, they present physical therapy as an autonomous clinical discipline to reduce or prevent impairments and functional limitations. In contrast, federal laws are very specific that the purpose of physical therapy in schools is to ensure that students participate in the educational process. School PT clients are *students* who qualify for instruction in special education because their disabilities adversely affect their educational performance. Therapists are obligated to provide educationally-related services and treat students' impairments only when improvement in those impairments will increase students' educational access and success (Blossom, Ford, Cruse, 1996).

Physical therapist (PT) responsibilities include screening, assessment, service provision and documentation. They should be knowledgeable about student eligibility and exit criteria. Budget/resources awareness including appropriate assessment materials, treatment supplies and equipment is also important. Therapists need to be skilled collaborators and communicators. They should be aware of how and what they communicate - think through carefully, plan and deliver communication in a style suitable to each recipient. For example, a formal presentation may be appropriate in one setting; a hand written note in another. At a minimum, administrators should ensure PT and physical therapist assistant job descriptions exist and are well communicated to them (See the following job descriptions).

2. Professional Standards

The director of special education is usually responsible for administration of physical therapy as a related service. The director oversees employment, supervision, budget preparation, IEP implementation, and accountability for related services.

Physical Therapists must be licensed by the Department of Public Health (DPH) to practice in Connecticut; Physical Therapist Assistants (PTAs) must register in Connecticut. Physical Therapist Assistants must receive supervision by a registered or licensed Physical Therapist responsible for assessments, reassessments and intervention-related decisions. The supervising physical therapist should be available to the physical therapist assistant at all times via telecommunications, and PTs must document delegation of treatment the PTA provides. PTAs must have an Associates (A.A.) Degree from an institution recognized by the Secretary of the U.S. Department of Education or the Council on Postsecondary Accreditations. Currently, accreditation standards for physical therapists and physical therapist assistants are established by the Commission on Accreditation in Physical Therapy Education. (See appendix: Connecticut Practice Act for Physical Therapist and Physical Therapy Assistant.)

In lieu of state certification requirements, recommended guidelines are that **same discipline supervision** is available for therapists with less than three years experience in pediatrics/school settings. (American Physical Therapy Association "Code of Ethics for Physical Therapists" and "Standards of Ethical Conduct for Physical Therapist Assistants" is in the appendices.)

3. Federal Regulations

Under IDEA Part B, physical therapy is a related service for eligible students ages 3 through 21 who require "..such developmental, corrective, and other supportive services as are required to assist a child with a disability to benefit from special education." It includes:

- "Improving, developing or restoring functions impaired or lost through illness, injury or deprivation;
- improving ability to perform tasks for independent functioning when functions are impaired or lost;
- preventing, through early intervention, initial or further impairment or loss of function."

Physical therapists maximize independent function of students with disabilities, prevent disabilities from increasing, and help students achieve and maintain health and productivity. The school PT helps students assume the student role, which may include:

- campus or school mobility;
- regular and timely participation in educational activities;
- storing materials;
- recording information;
- studying;
- activities of daily living;
- managing and using tools and supplies;
- participating in activities across school settings; and
- making transitions to job and leisure activities.

4. Supervision and Evaluation

Supervision is a process where two or more people in concert try to promote, establish, maintain and/or elevate the level of performance and service. A mutual undertaking between supervisor and subordinate, supervision fosters growth and development, effectively utilizes training and potential, and encourages creativity. Supervisors provide guidance, support, encouragement and respect while attaining goals. Supervision should promote quality physical therapy and professional development. The amount of supervision required varies, depending on the physical therapy practitioner's clinical experience, responsibilities, and expertise. Employment setting, service methods, practitioner competence, and service demands influence supervision quantity, degree and patterns.

Criteria for evaluating physical therapist assistants (PTAs) can include their skills in: time management, communication, instruction and planning. Also important is their knowledge in basic areas, ability to carry out fundamental professional responsibilities and to foster a positive learning climate. Particularly for the inexperienced PTA, it is important to offer constructive feedback during evaluations so that the staff member feels supported and encouraged to improve. (Sample performance appraisal forms for Physical Therapists and Physical Therapist Assistants are in the appendices.)

Physical therapists who provide services in educational settings but are actually employed by an outside contracted agency should be supervised by persons trained and qualified as physical therapy practitioners for their professional practices. Principals or other school administrators may administratively supervise physical therapy practitioners.

By virtue of their education and training, physical therapists have ultimate responsibility for services and provide them independently. However best practice is that new, entry-level PTs receive *close* supervision, and intermediate-level PTs receive *routine* or *general* supervision. Registered physical therapist assistants at all levels require at least general supervision by a PT -- additional supervision depending on the PTA's ability to safely and effectively provide interventions the PT delegates. These recommendations assume school system structures having same-profession supervision resources; they may not be feasible in small schools. Exchanging mentoring relationships with therapists in other school districts is one creative way to arrange for this level of same discipline input and supervision.

Supervision occurs along a continuum:

- close supervision - daily, direct contact at work site;
- routine supervision - direct contact at least every two weeks at work site, and interim supervision through telephone or written communication;
- general supervision - direct contact at least monthly with supervision available via other methods as needed, and
- minimal supervision - only as needed, possibly less than monthly.

The PT has an ethical responsibility to ensure supervision is consistent with the level of role performance, and changes with the practice situation. Supervision should be supportive, based on professional goals established annually. Goals may focus on acquiring personal and professional skills and knowledge specific to the educational setting. For each goal, an action plan with timelines can be reviewed at a mid-year and end-of-year conference between supervisor and subordinate. For each of three basic areas of potential impact, supervisors can evaluate and their employees self-evaluate how well they have:

- impacted student learning;
- contributed to program(s); and
- contributed to the organization.

Supervisors may conduct a formal evaluation the first year and subsequently on a three year cycle. If supervisors are not of the same discipline as the staff members, a peer supervisor or consultant should review discipline-specific job responsibilities such as assessment and treatment. At a minimum, the Local Education Agency supervisor, (usually the Special Education Director) monitors general performance such as attendance, punctuality, and timeliness with documentation. Depending on local school system structure, other areas including task performance fall within the Special Education Director's scope of supervision. Labor agreements may stipulate supervision standards. Additionally, school systems utilizing a case manager system might choose to involve case manager(s) in evaluating how well the PT functions in that system, using this information in professional development planning. (See appendices for CPTA supervision guidelines.)

5. Service Administration

A. Standards for physical therapy programs should be founded on the principles that pupil services are:

- an integral part of the total education program;
- organized and delivered to help all students achieve maximum benefits from the school program;
- organized and delivered to enable teachers, parents and other members of the school community to provide optimum teaching and learning conditions for students;
- comprehensive in scope, providing for service needs assessment, monitoring and documenting impact;
- supportive of student practicum opportunities for pre-service roles; and
- designed and delivered to ensure respect for rights and values of all program participants.

B. Service Time requirements for physical therapy is the sum of time necessary for a variety of functions, including but not limited to:

- screening and evaluation;
- physical therapy for all students' IEPs;
- required service for students not in IEPs;
- travel;
- case management;
- consultation;
- supervision and training;
- ordering, adjusting, storing, and cataloging adaptive equipment; and
- documentation/writing reports.

Both a legal requirement and a tool for evaluating physical therapists, documentation is also essential for obtaining third party payment where appropriate. Examples of documentation, records and planning activities are:

- obtaining medical information and medical referrals;
- preparing for IEP meetings;
- developing and revising services plan;
- maintaining attendance records;
- updating progress notes, including that required for third-party billing;
- writing therapy discontinuance reports;
- recording supervision meetings with assistants;
- preparing statistical reports;
- maintaining a record of therapy supplies and equipment;
- recording communications with parents and others; and
- preparing other documentation the LEA requires.

C. Therapy Service may be direct or indirect, in-groups or given individually. Collaboratively, the IEP team decides how much, often and long the LEA will provide a specific related service. Categories of direct or indirect treatment include:

- screenings;
- assessment/reassessment;
- service delivery;
- team collaboration;
- documentation including team development of IEP;
- monitoring;
- consultation;
- Planning and Placement Team meetings.

D. Caseload estimates should be derived through PT/administration collaborative planning. They need to take into account factors such as: treatment frequencies, severity of disability, travel time, team collaboration, and role release. Time can be used creatively, through blocking and appropriate grouping. Administrative support is necessary to enable therapists to set aside sufficient hours for communicating with educational personnel and families, and performing liaison to the medical community. Training for assistants, student interns and LEA staff also uses considerable PT time.

E. Other School Policies — PTs are responsible for familiarity with and implementation of local policies. If LEA policies conflict with professional ethics, the latter must override the former. Administrative support is necessary to resolve such conflicts in a manner that does not jeopardize licensure of the physical therapist or the registration of the physical therapy assistant. Many specific procedures related to physical therapy services within the school setting are determined locally, for example:

- policy on contacting parents;
- attendance at PPT's;
- designation of case managers;
- specific referral procedures.

6. Staff Development

Ultimately the physical therapy practitioner's responsibility, professional development is important to keep current with changes in educational regulations, professional standards, and new knowledge on best practice for therapists in school settings. A variety of resources and approaches for professional development exist to help physical therapists keep current on the many changes in service delivery and laws/regulations. University-based programs may not offer courses related to school settings. Sources for more targeted training include: mentoring arrangements, state- and APTA-sponsored seminars and conferences, Regional Educational Service Center (RESC) sponsored professional development activities, pre-and post-professional practicum opportunities, and professional literature. A pilot Regional Support Group sponsored by LEARN (the Regional Educational Service Center in Old Lyme, Connecticut) anticipates continuing its professional network/sharing opportunities in future years.

Professional development resources in the Appendix in these *Guidelines* include:

- bibliography (partial listing - extensive list at SERC);

- list of state resources/contacts;
- list of out-of-state sources; and
- SERC available journals list.

The Special Education Resource Center (SERC) in Middletown, Connecticut assists professionals and parents as they endeavor to provide an appropriate education for students with special needs. SERC's array of services, information and resources include:

- library services: extensive collection of books, journals, tests, pamphlets;
- research abstracts and indexes, references and in-service materials (see sample list in appendices);
- information/publication dissemination on programs and services in Connecticut;
- Child Find, which helps identify children who need services;
- the SERC Newsletter, published several times a year, containing announcements about training's and other activities/developments;
- in-service programs, seminars and conferences at SERC or at various locations throughout the state.

The six Regional Educational Service Centers offer technical assistance to school in their districts (See full names and contact details in appendices):

ACES, Hamden
CES, Trumbull
CREC, Hartford
LEARN, Old Lyme
EASTCONN, North Windham
EDUCATION CONNECTION, Litchfield

Sample Job Description

School Physical Therapist

Position Summary:

- Provides services to students eligible for related services
- Improves, develops, restores or maintains a child's sensory motor function in educational environments
- Functions as "related service personnel" under state and federal law and regulations
- Responsible to Director of Special Education

Qualifications:

- Bachelor's or Master's degree in physical therapy from a school accredited by the American Physical Therapy Association (credentialing organization must review foreign-trained PT qualifications)
- Licensed to practice physical therapy in Connecticut
- If less than three years experience in pediatrics and/or school setting, receive same discipline supervision or mentorship whenever available

Experience and Skills:

Must have skills and knowledge in the following areas:

1. identification and planning
2. program administration and management - participates in local education agency's comprehensive planning process; collaborates with the director of special education to establish implementation procedures; supervises physical therapist assistants and student practicum
3. intervention -including but not limited to:
   - facilitation of developmental motor skills
   - postural awareness, ambulation and gait training
   - sensorimotor processing
   - cardiovascular function
   - wheelchair mobility
   - adaptation or modification of equipment
   - recommendation and monitoring or orthoses and other assistive devices
   - prevention of initial or additional deformity or disability via early intervention and transportation needs of students

Essential Job Functions:

Must be able to perform the following job roles and functions:

- conduct appropriate evaluation of students referred for related services under IDEA and prepare written reports of the evaluations and findings
- participate in meetings as member of the multidisciplinary team
- participate in development of IEP's for eligible students
- provide direct and indirect physical therapy in educational settings to children with EEN
- collaborate with other school personnel regarding physical therapy and the students' needs
- delegate activities to teachers, parents and paraprofessionals
- work within case manager systems where relevant
- travel to and among schools to provide services
- maintain records of service provided
- lift, transfer and position children and equipment as necessary to provide physical therapy
- supervise any assigned physical therapist assistant(s)

Adapted from: *Occupational Therapy and Physical Therapy: A Resource and Planning Guide.* Madison, WI: Wisconsin Department of Public Instruction, 1996. Pages 184-5. Used with permission.

[Sample for consideration]

Sample Job Description

School Physical Therapist Assistant

Position Summary:

- Provides services to students eligible for related services, under the supervision of a physical therapist
- Follows a treatment plan developed by the physical therapist to improve, develop, restore or maintain students' sensory motor function in educational environments
- Functions as "related service personnel" under state and federal law and regulations

Responsible to:

- Director of Special Education; professionally under supervision of a licensed physical therapist

Qualifications:

- Completion of a physical therapist assistant associates degree program accredited by the American Physical Therapy Association
- Registered to practice as a physical therapist assistant in Connecticut
- Must be supervised by a licensed Physical Therapist who is responsible for assessments, reassessments, and intervention decisions.

Job Functions:

Provides physical therapy services delegated and supervised by a licensed physical therapist. Under supervision the physical therapist assistant:

- assists with data collection and performs specified measurements such as goniometry and manual muscle testing
- provides direct service according to a written treatment plan that the physical therapist develops
- assists the physical therapist in managing and maintaining the physical therapy service
- recommends treatment modifications to the physical therapist based on students' needs
- communicates and interacts with other team members, school personnel, and families in collaboration with a physical therapist
- maintains treatment areas, equipment, and supply inventory as the service plan requires
- maintains records and documentation as the service plan requires
- participates in policy and procedure development, in collaboration with a physical therapist.

Adapted from: *Occupational Therapy and Physical Therapy: A Resource and Planning Guide.* Madison, WI: Wisconsin Department of Public Instruction, 1996. Page 186. Used with permission.

[Sample for consideration]

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Appendices

Schematic - Service Provision Process

Abbreviations & Acronyms

Glossary

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List of Tools (annotated)

Ecological Assessment/Intervention

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ABBREVIATIONS & ACRONYMS

ADA	Americans with Disabilities Act
AES	Alternative Educational Setting
AOTA	American Occupational Therapy Association
APTA	American Physical Therapy Association
C.F.R.	Code of Federal Regulations
COTA	Certified Occupational Therapy Assistant
FAPE	Free Appropriate Public Education
IDEA	Individuals with Disabilities Education Act
IEP	Individualized Education Program
IFSP	Individualized Family Service Plan
LEA	Local Education Agency
LRE	Least-Restrictive Environment
OT	Occupational Therapy
OTR	Registered Occupational Therapist
PPT	Planning and Placement Team
PT	Licensed Physical Therapist
PTA	Physical Therapist Assistant
U.S.C.	United States Code

GLOSSARY

adapted physical education

specially designed instruction as prescribed in the IEP which allows students opportunity for active participation in developing physical and motor fitness, fundamental motor skills and patterns, and skills in aquatics, dance and individual and group games and sports, including intramural and lifetime sports appropriate to their individual needs.

adaptive skills

those skills used in daily living such as eating, dressing, sleeping.

advocacy

accessing information and acting on behalf of students' best interest.

assessment

specific tools or instruments used during the evaluation process.

assistive technology

may be part of students' supplementary aids and services, special education, or related services. An assistive technology device is any item, piece of equipment or product system that is used to increase, maintain, or improve the functional capabilities of students with disabilities. Devices can be acquired commercially and used off-the-shelf, modified, or customized to meet the students' needs. An assistive technology service directly helps students with disabilities to select, acquire or use an assistive technology device. A school occupational therapist or school physical therapist may be involved in providing an assistive technology service.

cognitive

ability to learn, understand and problem-solve.

curriculum-based assessment

using teaching curriculum as a criterion or reference to develop students' mastery. For example the third grade curriculum may be multiplication; assessments would evaluate whether or not students have mastered the curriculum content being taught in that third grade class.

developmental delay

being behind other students of the same age in one or more areas of development.

evaluation

the process of obtaining and interpreting data necessary for intervention-- includes planning for and documenting the evaluation process and results.

free appropriate public education

(FAPE) special education and related services provided at public expense under public supervision and at no charge; that meet the standards of the State educational agency; including an appropriate preschool, elementary or secondary school education in the State; and that is provided in conformity with the IEP.

goal-attainment scaling

an effective method of evaluating student performance in school-based occupational therapy practice, which determines whether student goals have been attained.

individualized education program

(IEP) a written statement for a student with a disability that is developed and implemented in accordance with 34 CFR 300.341-300.350. The IEP team determines special education and related services necessary to accomplish the goals, and determines the student's placement. The team initiates and conducts meetings to periodically review and, if appropriate, revise each student's

individualized education program. The team develops an individualized education program before the student receives special education and related services, and implements the IEP as soon as possible following an IEP meeting.

interdisciplinary team

comprised of professionals from various disciplines whose members use their skills and knowledge to work together on common purposes - they plan, coordinate and deliver services collaboratively.

least restrictive environment

(LRE) a key principle in the special education process. The law requires that to the maximum extent appropriate, school districts educate students with disabilities with students who do not have disabilities. The team, which develops the student's IEP, determines the extent to which a student will participate in the general education program. The team may remove a student from the general education environment only when teachers cannot educate the student satisfactorily in the general classroom using supplementary aids and services. In non-academic and extra curricular activities, such as meals, recess periods, clubs, athletics and student employment opportunities, each student with a disability has the right to participate with students who do not have disabilities.

multidisciplinary team

comprised of professionals from various disciplines whose members are responsible for common students or purposes, but use their skills and knowledge independently, periodically informing other team members.

occupational therapy

(OT) uses purposeful activity to maximize independence, prevent disability and maintain health among individuals with physical injury, illness, psychosocial dysfunction, developmental or learning disabilities. It teaches/develops skills such as: perceptual-motor, sensory integrative, daily living, psychosocial, prevocational, and play/leisure. The practice includes posture rehabilitation, tests and measurements of neuromuscular function, and treatment such as orthotic/prosthetic devices, adaptive equipment, and environmental adaptations. School based OT practice is limited to educationally related services. The Code of Federal Regulations (C.F.R.), I.D.E.A. Part B. defines occupational therapy as a related service.

Planning and Placement Team

(PPT) the group of public school team members who make decisions about identification, evaluation, services and placement for children aged 3-21 who receive special education and related services.

performance assessments

efforts to develop reliable and valid tests of how students perform in academic tasks as compared to merely measuring their knowledge of academic content.

portfolio assessments

evaluating or assessing student performance based on student work samples. The two main types are: looking at all work samples produced by a particular student from a specified period of time; and letting students select samples that they wish to submit for evaluation and assessment.

physical therapy
(PT) prevents or minimizes disability, relieves pain, develops and improves motor function, controls postural deviations, and establishes and maintains maximum performance within the individual's physical capabilities. PT's serves individuals with handicapping conditions resulting from prenatal causes, birth trauma, illness or injury. In an educational setting, PT services enable students with disabilities to benefit from special education in the least restrictive environment, through maximizing students' physical potential for independence and modifying/adapting students' physical environment.

qualified individual
per the 1973 Rehabilitation Act, Section 504, in public preschool, elementary and secondary schools, a qualified individual is an individual with disabilities who has (1) a physical or mental impairment which substantially limits one or more major life activities; or (2) a record or history of such an impairment; or (3) no physical or mental impairment that substantially limits a major life activity but the individual person is treated by the school district as having such a limitation. Major life activities include walking, seeing, hearing, speaking, breathing, learning, working, caring for one's self and performing manual tasks. The disability need only substantially limit one major life activity for the student to be considered as a qualified individual under Section 504.

rating scales
used to rate or judge the components required to perform a task at competency level. It requires task analysis, using a modified Likert-type scale to award points if students perform the task components. The performance criterion can be whatever is judged necessary.

related services
those necessary to assist students with disabilities to benefit from special education. IDEA specifically includes occupational therapy and physical therapy as related services.

screening
method to verify if students need further diagnostic evaluation, which takes a general, broad view of student skills.

special education
instruction that a team of school staff and parents specially designs to meet the unique needs of students with disabilities, and that the school provides at no cost to parents. It may include instruction in the: classroom, physical education, home, hospital, institution and other settings. A team, which evaluated the student, considers special education when general education with supplementary aids and services is insufficient to meet a student's educational needs. A student's special education program includes special education teacher services or a physical education teacher when specially designed physical education is used to implement the IEP.

transdisciplinary team
comprised of professionals from various disciplines who share expertise, skills and knowledge with each other; sharing roles when working together on common students or purposes. They plan collaboratively, train one another, and deliver services by sharing roles and responsibilities.

transition services
a coordinated set of activities for students, designed within an outcome-oriented process, that promotes movement from school to post-school activities, including: post-secondary education, vocational education, integrated employment (including supported employment), continuing and adult education, adult services, independent living or community participation. The IEP must include a statement of transition services needed for each student 14 years of age or older.

Sample Forms

[sample for consideration] *(See Guidelines for explanation of school based PT practice.)*

COMMON PEDIATRIC DIAGNOSES/CONDITIONS
SERVED BY PHYSICAL THERAPY in Schools

1. Developmental and neuromuscular disorders
   a. cerebral palsy
   b. developmental neurologic disorders
   c. developmental delay
   d. mental retardation
   e. minimal brain dysfunction
   f. infections of the brain, post acute stage

2. Spinal cord defects or diseases
   a. meningomyelocele and other neural tube defects
   b. spinal cord injuries, post acute stage
   c. spinal cord tumors

3. Peripheral nerve and muscular diseases
   a. muscular dystrophies
   b. congenital myopathy and benign congenital hypotonia
   c. peripheral nerve injuries--brachial plexus injury (birth)
   d. spinal muscular atrophies
   e. poliomyelitis, post acute
   f. polyneuropathy
   g. inherited neuropathies

4. Congenital anomalies
   a. arthrogryposis multiplex congenita (AMC)
   b. congenital limb deficiencies
   c. congenital deformities of the foot

5. Traumatic head injury

6. Respiratory disorders
   a. asthma
   b. cystic fibrosis

7. Inflammatory disorders of soft tissues and joints
   a. juvenile rheumatoid arthritis
   b. hemophilia

8. Other
   a. AIDS
   b. scoliosis
   c. degenerative diseases
   d. syndromes
   e. burns

Adapted from: Guidelines for Physical Therapy Practice in Educational Environments of Washington State. Olympia, WA: Washington State Physical Therapy Association, 1991. Used with permission.

[sample for consideration]

PRE-REFERRAL MOTOR SCREENING CHECKLIST

Child's Name: ______________________________

DOB: ____________________ Grade: ____________________

Please initial after completing checklist. Input needed from all staff listed below:

classroom teacher: ____________

special ed. teacher: ____________

physical ed. teacher: ____________

Check the problems below, which apply to this student. If not applicable, please state N/A

A. Poor Posture:

____ Head held to one side
____ Shoulder - one higher than the other
____ Hip - one higher than the other
____ Bowlegged
____ Knock Knees
____ Slouches

B. Clumsiness, Poor Coordination, Poor Awareness of Space:

____ Poor Balance
____ Falls Easily
____ Runs into chairs, desks
____ Trouble catching, kicking or throwing a ball
____ Cannot learn new motor activities or games
____ Behind others in motor skills
____ Poor use of one side of body
____ Makes facial grimaces or uncontrolled movements when working
____ Other: ____________

C. Excessive Restlessness:

____ Cannot sit still, fidgets
____ Other: ____________

D. Weakness or Floppiness of Arms or Legs:

____ Cannot easily get up from floor, chair
____ Trouble going up or down stairs
____ Appears to fatigue easily
____ Seems weak or stronger than normal
____ Other: ____________

E. Breathing Problems:

____ Difficulty breathing
____ Becomes short of breath
____ Chronic congestion
____ Other: ____________

F. Fine Motor Problems

____ Difficulty manipulating small objects (pegs, beads, coins)
____ Difficulty using scissors, coloring, writing
Please specify ____________
____ Abnormal Pencil Grip (holds tightly or weakly, immature grasp)
____ Jerky or tremor-like motions in hands when drawing
____ Difficulty staying on lines when tracing
____ Eyes do not follow hands, seem to wander
____ Difficulty using isolated finger movements (Uses arm & hand as one unit when writing)

G. Unusual Walking Pattern:

____ Limp
____ Feet turned in or out excessively
____ Walks on toes
____ Walks on heels
____ Drags one leg
____ Other: ____________

H. Seems Excessively Distracted by Stimulation

____ Dislikes light touch or being touched
____ Overreacts to unexpected touch or sound
____ Unable to calm down after motor activity
____ Other: ____________

I. Trouble with Attention:

____ Is lethargic at times
____ Stares blankly on occasion
____ Frequently misses directions
____ Has wandering eyes--cannot focus
____ Other: ____________

J. Pain or Discomfort:

____ Unusual or chronic complaints
____ Other: ____________

K. Equipment:

____ Wears braces, uses wheelchair, crutches or other appliances
____ (or)you feel student may benefit from these
____ Please specify: ______________________

L. Basic Sensory Functioning:

____ Pushes, shoves, kicks when standing in lines
____ Dislikes being touched
____ Prefers touching rather than being touched
____ Difficulty identifying objects by touch alone
____ Excessive mouthing of objects
____ Cannot find body parts with eyes closed
____ Fearful of movement (example: going up and down stairs)
____ Never gets dizzy (craves spinning & rolling)
____ Gets dizzy easily (avoids spinning & rolling)

M. Visual Perceptual Problems:

____ Has a diagnosed visual defect
____ Poor understanding of spatial concepts (large, small, and numbers)
____ Poor directional concepts (up, down, right, left, in, out)
____ Difficulty putting puzzles together
____ Difficulty recognizing shapes and colors
____ Difficulty identifying object from background
____ Poor spacing of work on paper
____ Reverses letters, numbers, words or phrases
____ Difficulty eye tracking

N. Auditory sensation

____ Overly sensitive to noise
____ Misses sounds
____ Likes to make loud noises
____ Has hearing loss

O. Social/Emotional Problems

____ Verbally aggressive
____ Behavior bothers others
____ Happiest playing alone, isolates self
____ Cries easily
____ Fearful of new situations
____ Easily frustrated
____ Falls asleep in class
____ Can't calm down
____ Physically aggressive
____ Attention seeking
____ Impulsive
____ Lacks confidence

P. Bilateral Integration Problems:

____ Avoids or has difficulty performing tasks which require eyes or extremities to cross midline
____ Neglects or seems unaware of one side
____ Doesn't stabilize paper while writing
____ Seems to ignore half of a page
____ Has an inconsistent hand dominance
____ Always uses both hands together

Q. Learning Behavior:

____ Short attention span
____ Difficulty with change in routine
____ Difficulty recognizing own errors
____ Difficulty working independently:
 ________ slow worker
 ________ easily distracted
 ________ perservates
 ________ disorganized, messy
 ________ talks aloud, hums, sings
 ________ rushes through work

R. Activities of daily living

____ Trouble dressing/undressing (or fastening, buttoning, zipping, shoe tying)
____ Needs assistance when toileting
____ Trouble grooming (teeth, face)
____ Trouble eating (Please explain: __________
____
____ Drools:
 ________ always
 ________ only under stress
 ________ only when eating
____ Avoids eating certain textures of food

How do these problems affect his/her learning?

____
____
____
____

Comments or additional observations:

____
____
____
____

Please complete -- school nurse will have information: (please print)

Any known medications: ____

Any known surgery: ____

Any known seizures: If yes, type: ________________ Frequency: ____________________

Other agencies involved: ____

Child's physician: ____

Address: ____

Telephone Number: ____

Any previous OT or PT Therapy: ________ Yes ________ No

If yes, please indicate if reports are available:________ Yes ________ No

Adapted from: *Guidelines for Providing Occupational, Physical and Speech/Language Therapy in the Schools.* Fairfield, CT: related Services Task Force, Fairfield County and Cooperative Educational Services, 1993. Used with permission.

List of Tools (Annotated)

IDEA Summary & Excerpts

IDEA 1977 AMENDMENTS - Summary

The original 1975 Public Law 94-142 has been amended many times. The latest amendments focus on seven areas key to physical and occupational therapy: State/districtwide assessments, IEP's, parent participation, evaluations, transition planning, voluntary mediation, and discipline/behavior.

State/districtwide assessments - States required to include children with disabilities, with accommodations when necessary, in State and districtwide assessment (testing) programs.

charter and private schools - children with disabilities must also be identified and under certain conditions receive special education services

children in adult prisons - will receive special education and related services through the state-designated agency

IEP's - in addition to previous IDEA requirements, must include information on:

a) how the child's disability affects involvement and progress in the general curriculum
b) special education, related services, and supplementary aids/services child needs to: be involved and progress in the general curriculum; participate in extracurricular and other nonacademic activities; and be educated and participate with other children with disabilities and nondisabled children
c) extent to which child will not participate with nondisabled children in general education, extracurricular and non-academic activities.
d) how State/districtwide assessments will be modified so student can participate. If student cannot, why and alternatives
e) transition service needs starting at age 14
f) how students will be informed about rights at age of majority, and parents regularly informed about child's progress meeting annual IEP goals

IEP's - general educator role in IEP development increased, and "special factors" to consider added:

a) behavior strategies if child's behavior impedes his or others' learning
b) child's language needs related to IEP if limited English proficiency
c) Braille instruction if blind/visually impaired
d) communication needs and specific factors if deaf/hard of hearing
e) whether child needs assistive devices and services.

IEP's - reviews and revisions:

a) at least annually, revision as needed
b) schools must report to parents on progress of child with disabilities at least as frequently as progress of nondisabled children reported
c) if child not making expected progress toward annual goals and in general curriculum, IEP team must meet and revise IEP

Reevaluations - IEP team *is not required to reevaluate child if* they reviewed existing evaluation data and sought parent input and could determine there is enough information to decide whether:

a) child continues to have a disability and need special education and related services
b) child's present levels of performance and educational needs
c) whether modifications to special education and related services needed for child to meet IEP goals and participate in general curriculum.

parents - must be:

a) included in group making eligibility and placement decisions
b) notified that IEP team determines reevaluation not needed
c) informed of right to request their child be reevaluated
d) asked for consent to reevaluate child

e) allowed to review all records

mediation - becomes primary process to resolve conflicts between school and parents of a child with disability. State must ensure it is voluntary, maintain list of qualified mediators, and pay for mediators.

discipline/behavior - issues, definitions, situations covered include: weapon or illegal drugs, alternative educational placements, hearing officer role, "substantial" evidence, "manifestation" determination reviews (MDR's), appeals, referral to law enforcement and judicial authorities.

a) when disciplinary action considered, must have MDR to assess relationship between the child's disability and the behavior subject to the disciplinary action

b) the IEP team and other qualified personnel conduct MDR. They "may determine that the behavior of the child was not a manifestation of such child's disability only if the IEP Team:
(i) first considers, in terms of the behavior subject to disciplinary action, all relevant information, including - (I) evaluation and diagnostic results, including such results or other relevant information supplied by the parents of the child; (II) the child's disability did not impair the ability of the child to understand the impact and consequences of the behavior subject to disciplinary action; and (III) the child's disability did not impair the ability of the child to control the behavior subject to disciplinary action." [Section 615(k)(4)(C)]

c) a child who violated a rule or code of conduct can assert protections of the Act if the LEA had knowledge of the disability through: the parent expressing concern in writing or requesting an evaluation; the child's behavior or performance indicating services are needed; or "(iv) the teacher of the child or other personnel of the local educational agency has expressed concern about the behavior or performance of the child to the director of special education of such agency or to other personnel of the agency". (Sec 615(k)(8)(B)]

developmental delay - at State's discretion, children with disabilities ages 3-9 can include a child: "(1) experiencing developmental delays, as defined by the State and as measured by appropriate diagnostic instruments and procedures, in one or more of the following areas: physical development, cognitive development, communication development, social or emotional development, or adaptive development"

related services - specifically includes orientation and mobility services. Also, "related services" now included in definition of transition services [Section 602(30)]

supplementary aids and services - defined as "...aids, services, and other supports that are provided in regular education classes or other education-related settings to enable children with disability to be educated with nondisabled children to the maximum extent appropriate in accordance with section 612(a)(5)." [latter section refers to least restrictive environment requirements]

procedural safeguards - requirements for nondiscriminatory testing: "Additional procedural safeguards.- Procedures to ensure that testing and evaluation materials and procedures utilized for the purposes of evaluation and placement of children with disabilities will be selected and administered so as not to be racially or culturally discriminatory. Such materials or procedures shall be provided and administered in the child's native language or mode of communication, unless it is clearly not feasible to do so, and no single procedure shall be the sole criterion for determining an appropriate educational program for a child." [Section 612(a)(6)(B)]

performance goals and indicators - States must establish performance goals and progress indicators for children with disabilities.

Reference: News Digest. Volume 26. National Information Center for Children and Youth with Disabilities.August 1997.

EXCERPTS FROM GOVERNMENT WEB PAGE - 1997 IDEA AMENDMENTS

(a) Evaluations and Reevaluations. - -

(1) Initial Evaluations. - -

(A) In general. - - A State educational agency, other State agency, or local educational agency shall conduct a full and individual initial evaluation, in accordance with this paragraph and subsection (b), before the initial provision of special education and related services to a child with a disability under this part.

(B) Procedures. - - Such initial evaluation shall consist of procedures - -

(i) to determine whether a child is a child with a disability (as defined in section 602(3));

(ii) to determine the educational needs of such child.

(C) Parental Consent. - -

(i) In general. - - The agency proposing to conduct an initial evaluation to determine if the child qualifies as a child with a disability as defined in section 602(3)(A) or 602(3)(B) shall obtain an informed consent from the parent of such child before the evaluation is conducted. Parental consent for evaluation shall not be construed as consent for placement for receipt of special education and related services.

(ii) Refusal. - - If the parents of such child refuse consent for the evaluation, the agency may continue to pursue an evaluation by utilizing the mediation and due process procedures under section 615, except to the extent inconsistent with State law relating to parental consent.

(2) Reevaluations. - - A local educational agency shall ensure that a reevaluation of each child with a disability is conducted - -

(A) if conditions warrant a reevaluation or if the child's parent or teacher requests a reevaluation, but at least once every 3 years; and

(B) in accordance with subsections (b) and (c).

(b) Evaluation Procedures. - -

(1) Notice. - - The local educational agency shall provide notice to the parents of a child with a disability, in accordance with subsections (b)(3), (b)(4), and (c) of section 615, that describes any evaluation procedures such agency proposes to conduct.

(2) Conduct of Evaluation. - - In conducting the evaluation, the local educational agency shall - -

(A) use a variety of assessment tools and strategies to gather relevant functional and developmental information, including information provided by the parent, that may assist in determining whether the child is a child with a disability and the content of the child's individualized education program, including information related to enabling the child to be involved in and progress in the general curriculum or, for preschool children, to participate in appropriate activities;

(B) not use any single procedure as the sole criterion for determining whether a child is a child with a disability or determining an appropriate educational program for the child;

(C) use technically sound instruments that may assess the relative contribution of cognitive and behavioral factors, in addition to physical or developmental factors.

(3) Additional Requirements- Each local educational agency shall ensure that - -

(A) tests and other evaluation materials used to assess a child under this section

(i) are selected and administered so as not to be discriminatory on a racial or cultural basis;

(ii) are provided and administered in the child's native language or other mode of communication, unless it is clearly not feasible to do so; and

(B) any standardized tests that are given to the child - -

(i) have been validated for the specific purpose for which they are used;

(ii) are administered by trained and knowledgeable personnel; and

(iii) are administered in accordance with any instructions provided by the producer of such tests;

(C) the child is assessed in all areas of suspected disability; and

(D) assessment tools and strategies that provide relevant information that directly assists persons in determining the educational needs of the child are provided.

(4) Determination of Eligibility. - - Upon completion of administration of tests and other evaluation materials - -

(A) the determination of whether the child is a child with a disability as defined in section 602(3) shall be made by a team of qualified professionals and the parent of the child in accordance with paragraph (5); and

(B) a copy of the evaluation report and the documentation of determination of eligibility will be given to the parent.

(5) Special Rule for Eligibility Determination. - - In making a determination of eligibility under paragraph (4)(A), a child shall not be determined to be a child with a disability if the determinant factor for such determination is lack of instruction in reading or math or limited English proficiency.

(c) Additional Requirements for Evaluation and Reevaluations. - -

(1) Review of Existing Evaluation Data. - - As part of an initial evaluation (if appropriate) and as part of any reevaluation under this section, the IEP Team described in subsection (d)(1)(B) and other qualified professionals, as appropriate, shall - -

(A) review existing evaluation data on the child, including evaluations and information provided by the parents of the child, current classroom-based assessments and observations, and teacher and related services providers observation; and

(B) on the basis of that review, and input from the child's parents, identify what additional data, if any, are needed to determine - -

(i) whether the child has a particular category of disability, as described in section 602(3), or, in case of a reevaluation of a child, whether the child continues to have such a disability;

(ii) the present levels of performance and educational needs of the child;

(iii) whether the child needs special education and related services, or in the case of a reevaluation of a child, whether the child continues to need special education and related services; and

(iv) whether any additions or modifications to the special education and related services are needed to enable the child to meet the measurable annual goals set out in the individualized education program of the child and to participate, as appropriate, in the general curriculum.

(2) Source of Data. - - The local educational agency shall administer such tests and other evaluation materials as may be needed to produce the data identified by the IEP Team under paragraph (1)(B).

(3) Parental Consent. - - Each local educational agency shall obtain informed parental consent, in accordance with subsection (a)(1)(C), prior to conducting any reevaluation of a child with a disability, except that such informed parent consent need not be obtained if the local educational agency can demonstrate that it had taken reasonable measures to obtain such consent and the child's parent has failed to respond.

(4) Requirements if Additional Data are not Needed. - - If the IEP Team and other qualified professionals, as appropriate, determine that no additional data are needed to determine whether the child continues to be a child with a disability, the local educational agency - -

(A) shall notify the child's parents of - -

(i) that determination and the reasons for it; and

(ii) the right of such parents to request an assessment to determine whether the child continues to be a child with a disability; and

(B) shall not be required to conduct such an assessment unless requested to by the child's parents.

(5) Evaluations before Change in Eligibility. - - A local educational agency shall evaluate a child with a disability in accordance with this section before determining that the child is no longer a child with a disability.

(d) Individualized Education Programs. - -

(1) Definitions. - - As used in this title:

(A) Individualized Education Program. - - The term 'individualized education program' or 'IEP' means a written statement for each child with a disability that is developed, reviewed, and revised in accordance with this section and that includes - -

(i) a statement of the child's present levels of educational performance, including - -

(I) how the child's disability affects the child's involvement and progress in the general curriculum; or

(II) for preschool children, as appropriate, how the disability affects the child's participation in appropriate activities;

(ii) a statement of measurable annual goals, including benchmarks or short-term objectives, related to - -

(I) meeting the child's needs that result from the child's disability to

enable the child to be involved in and progress in the general curriculum; and

(II) meeting each of the child's other educational needs that result from the child's disability;

(iii) a statement of the special education and related services and supplementary aids and services to be provided to the child, or on behalf of the child, and a statement of the program modifications or supports for school personnel that will be provided for the child - -

(I) to advance appropriately toward attaining the annual goals;

(II) to be involved and progress in the general curriculum in accordance with clause (i) and to participate in extracurricular and other nonacademic activities; and

(III) to be educated and participate with other children with disabilities and nondisabled children in the activities described in this paragraph;

(iv) an explanation of the extent, if any, to which the child will not participate with nondisabled children in the regular class and in the activities described in clause (iii);

(v) (I) a statement of any individual modifications in the administration of State or district-wide assessments of student achievement that are needed in order for the child to participate in such assessment; and

(II) if the IEP Team determines that the child will not participate in a particular State or district-wide assessment of student achievement (or part of such an assessment), a statement of - -

(aa) why that assessment is not appropriate for the child; and

(bb) how the child will be assessed;

(vi) the projected date for the beginning of the services and modifications described in clause (iii), and the anticipated frequency, location, and duration of those services and modifications;

(vii) (I) beginning at age 14, and updated annually, a statement of the transition service needs of the child under the applicable components of the child's IEP that focuses on the child's courses of study (such as participation in advanced - placement courses or a vocational education program);

(II) beginning at age 16 (or younger, if determined appropriate by the IEP Team), a statement of needed transition services for the child, including, when appropriate, a statement of the interagency responsibilities or any needed linkages; and

(III) beginning at least one year before the child reaches the age of majority under State law, a statement that the child has been informed of his or her rights under this title, if any, that will transfer to the child on reaching the age of majority under section 615(m); and

(viii) a statement of - -

(I) how the child's progress toward the annual goals described in clause (ii) will be measured; and

(II) how the child's parents will be regularly informed (by such means as periodic report cards), at least as often as parents are informed of their nondisabled children's progress, of - -

(aa) their child's progress toward the annual goals described in clause (ii); and

(bb) the extent to which that progress is sufficient to enable the child to achieve the goals by the end of the year.

(B) Individualized Education Program Team. - - The term 'individualized education program team' or 'IEP Team' means a group of individuals composed of - -

(i) the parents of a child with a disability;

(ii) at least one regular education teacher of such child (if the child is, or may be, participating in the regular education environment);

(iii) at least one special education teacher, or where appropriate, at least one special education provider of such child;

(iv) a representative of the local educational agency who - -

(I) is qualified to provide, or supervise the provision of, specially designed instruction to meet the unique needs of children with disabilities;

(II) is knowledgeable about the general curriculum; and

(III) is knowledgeable about the availability of resources of the local educational agency;

(v) an individual who can interpret the instructional implications of evaluation results, who may be a member of the team described in clauses (ii) through (vi);

(vi) at the discretion of the parent or the agency, other individuals who have knowledge or special expertise regarding the child, including related services personnel as appropriate; and

(vii) whenever appropriate, the child with a disability.

(3) Development of IEP. - -

(A) In General. - - In developing each child's IEP, the IEP Team, subject to subparagraph (C), shall consider - -

(i) the strengths of the child and the concerns of the parents for enhancing the education of their child; and

(ii) the results of the initial evaluation or most recent evaluation of the child.

(B) Consideration of Special Factors - The IEP Team shall - -

(i) in the case of a child whose behavior impedes his or her learning or that of others, consider, when appropriate, strategies, including positive behavioral interventions, strategies, and supports to address that behavior;

(ii) in the case of a child with limited English proficiency, consider the language needs of the child as such needs relate to the child's IEP;

(v) consider whether the child requires assistive technology devices and services.

(C) Requirement with Respect to Regular Education Teacher - The regular education

teacher of the child, as a member of the IEP Team, shall, to the extent appropriate, participate in the development of the IEP of the child, including the determination of appropriate positive behavioral interventions and strategies and the determination of supplementary aids and services, program modifications, and support for school personnel consistent with paragraph (1)(A)(iii).

(4) Review and Revision of IEP -

(A) In General - The local educational agency shall ensure that, subject to subparagraph (B), the IEP Team -

(i) reviews the child's IEP periodically, but not less than annually to determine whether the annual goals for the child are being achieved; and

(ii) revises the IEP as appropriate to address - -

(I) any lack of expected progress toward the annual goals and in the general curriculum, where appropriate;

(II) the results of any reevaluation conducted under this section;

Source- http://www.ed.gov/offices/OSERS/IDEA

Professional Development Resources

RESOURCES Contact Information

American Occupational Therapy Association, Inc.
4720 Montgomery Lane, P.O. Box 31220
Bethesda, MD 20824-1220

American Physical Therapy Association
111 North Fairfax Street
Alexandria, VA 22314
(800) 999-APTA

Brain Injury Association of Connecticut
(800) 278-8242

Child Abuse & Neglect (Connecticut)
(800) 842-2288

Child Find
(800) 842-6878

Connecticut Board of Education & Services for the Blind
(800) 842-4510

Connecticut Commission on the Deaf & Hearing Impaired
(800) 708-6796

Connecticut Occupational Therapy Association
125 Douglas Street
Hartford, CT 06114
(860) 956-0555

Connecticut Physical Therapy Association
330 Main Street
Hartford, CT 06106
(860) 246-4414

Department of Children and Families
505 Hudson Street
Hartford, CT 06105
(860) 550-6484

Department of Education
165 Capitol Avenue
Hartford, CT
(860) 566-5497

Department of Labor
Occupational Safety and Health
200 Folly Brook Blvd.
Wethersfield, CT 06109
(860) 566-4380

Department of Mental Health and Addiction Services
410 Capitol Avenue
Hartford CT 06106
(860) 418-7000

Department of Public Health
410/450 Capitol Avenue
Hartford CT 06106
(860) 509-8000

School and Adolescent Health Program
(860) 509-8057

Children With Special Health Care Needs
(860) 509-8074

Licensing: Occupational Therapists & Assistants
(860) 509-7561

Licensing: Physical Therapists
(860) 509-7566

INFO-LINE
(800) 203-1234

Medicaid
(860) 566-5900
TDD/TT 566-7013

New England SERVE
101 Tremont Street
Suite 812
Boston, MA 02108
(617) 574-9493

Office of Protection and Advocacy for Persons with Disabilities
60 B Weston Street
Hartford CT 06120
(800) 842-7303

REGIONAL EDUCATIONAL SERVICE CENTERS IN CONNECTICUT:

Area Cooperative Educational Services **(ACES)**
205 Skiff Street
Hamden, CT 06517-1095
Tel 407-4400. Fax 407-4590.
young@aces.k12ct.us

Capitol Region Education Council **(CREC)**
111 Charter Oak Avenue
Hartford, CT 06106-1912
Tel (860) 247-CREC (2732). Fax 246-3304
jallison@crec.org

Cooperative Educational Services **(CES)**
25 Oakview Drive
Trumbull, CT 06611
Tel (203)365-8800. Fax 365-8804

EASTCONN
376 Hartford Turnpike
North Windham, CT 06256-1612
Tel (860)455-0707. Fax 455-0691
dcalcher@eastconn.k12.ct.us

EDUCATION CONNECTION
355 Goshen Road, P.O. Box 909
Litchfield, CT 06759-0909
Tel (860)567-0863. Fax (860)567-3381
tedder@educationconnection.k12.ct.us

LEARN
44 Hatchett Hill Road
P.O. Box 805
Old Lyme, CT 06371
Tel (860)434-4800. Fax 434-4837
vseccomb@learn.k12.ct.us

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Sample Listing of Journals and Newsletters

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Active Living
Adapted Physical Activity Quarterly
ADHD Report
American Journal of Occupational Therapy
American Rehabilitation
Cognitive Development
Current Index to Journals in Education
Disability and Society
Education Index
Educational Technology
Exceptional Children
Inclusion Times
Individuals with Disabilities Education Law
Individuals with Disabilities Law Report
International Journal of Disability, Development and Education
Intervention in School and Clinic
Journal for Vocational Special Needs Education
Journal of Communication Disorders
Journal of Developmental and Physical Disabilities
Journal of Head Trauma Rehabilitation
Journal of Learning Disabilities
Journal of Pediatric Health Care
Journal of Rehabilitation
Journal of Special Education Technology
Journal of the Association for Persons with Severe Handicaps
Journal of Vocational Rehabilitation
Mental and Physical Disability Law
Pediatric Physical Therapy
Perceptual and Motor Skills
Physical and Occupational Therapy in Pediatrics
Physical Disabilities: Education and Related Services
Rehabilitation Counseling Bulletin
Rehabilitation Literature
Remedial and Special Education
Research in Developmental Disabilities
Section 504 Compliance Handbook
Sensory Aids Technology
Special Services in Schools
Technology and Disability

SERC, 25 Industrial Park Road, Middletown, CT 06457. (860)632-1485

STATE RESOURCES for DEVELOPING
OCCUPATIONAL THERAPY GUIDELINES
in the SCHOOL SETTING

IOWA

"Iowa Guidelines for Educationally Related Physical and Occupational Therapy Services", Des Moines, Iowa: Department of Education, 1993

State of Iowa
Department of Education
Grimes State Office Building
Des Moines, Iowa 5-319-0146

KANSAS

"Kansas Guidelines for Occupational and Physical Therapy Services in Educational Settings", Topeka, KS: Kansas State Department of Education, 1989

Kansas State Department of Education
120 East 10th Street
Topeka, KS 66612

MARYLAND

"Guide for Occupational Therapy and Physical Therapy Services in Maryland Public Schools", Annapolis, MD, 1990

OT & PT Services
Programs and Services
Highland Park Staff Development Center
6501 Lowland Drive
Landover, MD 20785

MONTANA

"Guidelines for the Provision of Occupational Therapy and Physical Therapy Services Under the Individual with Disabilities Education Act (IDEA)", Montana Office of Public Instruction, Helena, Montana, July 1997

OREGON

The Role of the Physical Therapist and Occupational Therapist in the School Setting (1989) ($8.00)

CDRC Publications
CDRC/OHSU
PO Box 574
Portland, Oregon 97207-0574

VERMONT

"Guidelines for Occupational and Physical Therapy Services in Vermont Schools", Vermont Department of Education, 1991

WISCONSIN

"Occupational Therapy and Physical Therapy - A Resource and Planning Guide", Madison, WI: Wisconsin Department of Public Instruction, 1996

State of Wisconsin
Department of Public Instruction
125 S. Webster Street
Madison, WI 53702
1-800-243-8782

OTHER--

"Occupational Therapy Services for Children and Youth under the Individuals with Disabilities Education Act", Bethesda, MD: The American Occupational Therapy Association, Inc., 1997

To obtain a copy of the Code of Federal Regulations, write to:

Superintendent of Documents
U.S. Governments Printing Office
Washington, DC 2040

Request 34 Code of Federal Regulations--Parts 300 to 399 (the most recent revision). The Code of Federal Regulations is revised annually. The 34 denotes regulations dealing with education.

Sample Appraisal Forms

[sample for consideration]

Performance Appraisal
PHYSICAL THERAPIST

Instructions: Rate each element of performance using the numerical values below. Average for each heading to determine appraisal.

1 = unsatisfactory 3 = meets expectations 0 = not applicable
2 = needs improvement 4 = exceeds expectations

EVALUATION
________ seeks medical information following appointment to interdisciplinary team and prior to conducting an evaluation
________ evaluates child using procedures appropriate for EEN identification and planning intervention
________ documents in an individual report
________ communicates and interprets results to the team, parents and other appropriate individuals
________ complies with confidentiality and consent laws and standards
________ adheres to time frames required by law and school policy
Comments: ____

PLANNING
________ collaborates with school personnel and parents to develop an IEP
________ recommends appropriate contexts and models for occupational therapy intervention
________ identifies assistive technology necessary to implement the IEP
________ discusses community resources that may benefit the child
________ documents an occupational therapy treatment plan based on the IEP
Comments: ____

INTERVENTION
________ implements the physical therapy treatment plan
________ collaborates with other school personnel and parents to provide services
________ records treatment provided, child's progress, and change in child's status on an ongoing basis
________ modifies treatment plan based on child's response and progress toward goals
________ provides the amount, frequency and duration of physical therapy specified in the IEP
________ discusses discontinuance of physical therapy at IEP meeting
Comments: ____

SUPERVISION
________ determines and adheres to appropriate level of supervision for physical therapy assistants
________ determines service competency of PTA's and delegates therapy for selected children
________ documents supervisory visits and modifications of children's treatment plans
________ supervises physical therapy aides and students
________ communicates expectations clearly and collaborates with PTA, aide or student to solve problems
Comments: ____

OTHER
________ maintains licensure as required by law
________ adheres to school district policies
________ maintains records required by Medicaid or insurance payers
________ maintains equipment, supplies, and designated space
________ evaluates the service and performs quality improvement activities
________ provides in-service education to other team members, parents and/or community

_______ monitors own performance and identifies supervisory and continuing education needs

Comments: ____

____

Evaluator's summary comments: ____

____

____

Physical therapist's summary comments: ____

____

____

____________________________ ____________________________

Evaluator's signature and date Physical therapist's signature and date

Adapted from: *Occupational Therapy and Physical Therapy: A Resource and Planning Guide.* Madison, WI: Wisconsin Department of Public Instruction, 1996. Pages 90-91. Used with permission.

[sample for consideration]

Performance Appraisal
PHYSICAL THERAPY ASSISTANT

Instructions: Rate each element of performance using the numerical values below. Average for each heading to determine appraisal.

1 = unsatisfactory 3 = meets expectations 0 = not applicable
2 = needs improvement 4 = exceeds expectations

EVALUATION

_______ assists the physical therapist with data collection
_______ assists the physical therapist with recording and documenting evaluation results
_______ complies with confidentiality and consent laws and standards
Comments: ____

PLANNING

_______ establishes service competency in collaboration with the OTR for designated intervention procedures
Comments: ____

INTERVENTION

_______ implements the physical therapy treatment plan under supervision of the physical therapist
_______ collaborates with other school personnel and parents to provide services
_______ documents intervention procedures and the child's response
_______ recommends modifications of intervention to the physical therapist
_______ adapts environments, tools, materials, and activities as the child needs
Comments: ____

OTHER

_______ maintains registration as required by law
_______ adheres to school district policies
_______ maintains equipment, supplies and designated space
_______ assists the physical therapist in:
- maintaining record keeping and reporting system
- evaluating the service and performing quality improvement activities
- providing in-service education to other team members, parents or community
- providing fieldwork experience to PT and PTA students

_______ monitors own performance and identifies supervisory and continuing education needs
Comments: ____

Evaluator's summary comments: ____

PTA's summary comments: ____

______________________ ______________________
Evaluator's signature and date PTA's signature and date

Adapted from: *Occupational Therapy and Physical Therapy: A Resource and Planning Guide.* Madison, WI: Wisconsin Department of Public Instruction, 1996. Page 96. Used with permission.

Professional Standards

Excerpts from Relevant Practice Acts
Health Professionals Licensed in State of Connecticut

Connecticut General Statute Chapter 376, Sec. 20-66 Definitions:

(1) "Physical therapist" means a person licensed to practice physical therapy in Connecticut as defined in subdivision (2) of this section;

(2) "Physical therapy" means the evaluation and treatment of any person by the employment of the effective properties of physical measures, the performance of tests and measurements as an aid to evaluation of function and the use of therapeutic exercises and rehabilitative procedures, with or without assistive devices, for the purpose of preventing, correcting or alleviating a physical or mental disability. Physical therapy includes the establishment and modification of physical therapy programs, treatment planning, instruction, peer review and consultative services. "Physical therapy" does not include the use of cauterization or the use of Roentgen rays or radium for diagnostic or therapeutic purposes; and

(3) "Physical therapist assistant" means a graduate of a physical therapist assistant program licensed by the Connecticut board of governors for higher education or approved by the American Physical Therapy Association or other professional accrediting association approved by the United States Department of Education and recognized by the commissioner of public health and addiction services or a person who has completed twenty years of employment as a physical therapist assistant prior to October 1, 1989.

(4) Sec. 3. Section 20-73 is repealed and the following is substituted in lieu thereof:

(5) (a)...The treatment of human ailments by physical therapy shall only be performed by a person licensed under the provisions of this chapter as a physical therapist upon the oral or written referral of a person licensed in this state or in a bordering state having licensing requirements meeting the approval of the appropriate examining board in this state to practice medicine and surgery, osteopathy, podiatry, naturopathy, chiropractic or dentistry, or an advanced practice registered nurse licensed to prescribe in accordance with section 20-94a or a physician assistant licensed to prescribe in accordance with section 20-12d….

American Physical Therapy Association

APTA Core Documents - January 1998

1. CODE OF ETHICS for PHYSICAL THERAPISTS

This *Code of Ethics* sets forth ethical principles for the physical therapy profession. Members of this profession are responsible for maintaining and promoting ethical practice. This *Code of Ethics*, adopted by the American Physical Therapy Association, shall be binding on physical therapists who are members of the Association.

Principle 1

Physical therapists respect the rights and dignity of all individuals.

Principle 2

Physical therapists comply with the laws and regulations governing the practice of physical therapy.

Principle 3

Physical therapists accept responsibility for the exercise of sound judgment.

Principle 4

Physical therapists maintain and promote high standards for physical therapy practice, education and research.

Principle 5

Physical therapists seek remuneration for their services that is deserved and reasonable.

Principle 6

Physical therapists provide accurate information to the consumer about the profession and about those services they provide.

Principle 7

Physical therapists accept the responsibility to protect the public and the profession from unethical, incompetent, or illegal acts.

Principle 8

Physical therapists participate in efforts to address the health needs of the public.

Adopted by the House of Delegates, June 1981. Amended June 1987, June 1991.

2. STANDARDS OF ETHICAL CONDUCT for the Physical Therapist Assistant

Preamble

Physical therapist assistants are responsible for maintaining and promoting high standards of conduct. These *Standards of Ethical Conduct for the Physical Therapist Assistant* shall be binding on physical therapist assistants who are affiliate members of the Association.

Standard 1

Physical therapist assistants provide services under the supervision of a **physical therapist.**

Standard 2

Physical therapist assistants respect the rights and dignity of all individuals.

Standard 3

Physical therapist assistants maintain and promote high standards in the provision of services, giving

the welfare of the patients their highest regard.

Standard 4

Physical therapist assistants provide services within the limits of the law.

Standard 5

Physical therapist assistants make those judgments that are commensurate with their qualifications as physical therapist assistants.

Standard 6

Physical therapist assistants accept the responsibility to protect the public and the profession from unethical, incompetent, or illegal acts.

Adopted by House of Delegates, June 1982. Amended June 1991.

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