Monroe County ADHD Task Force

Best Practice Manual

A Model for Communication

January 1998

To Whom It May Concern:

It is our intent that this ADHD manual serve as a resource and effective communication guide for school districts and health care professionals. The Monroe County ADHD Task Force recognizes there are vast differences in how ADHD concerns are handled within our county. As stated in the Dedication, the initial driving force for this project was to "improve communication between all the players." Over the last two years, Task Force members have done just this and, as a result, have developed a greater appreciation of one another's roles, whether as educator, health care provider, or parent.

We certainly hope you find this manual helpful and encourage you to adapt its contents to meet your needs. We ask for your assistance in distributing this information to appropriate individuals. Within a few months, you will be sent a survey to share with individuals who use the ***Best Practice Manual*** and can provide the Task Force with feedback.

The final phase of this project is implementation, which only you can make happen. We thank you for your assistance and support in improving communication within the educational and medical fields regarding students with ADHD.

Sincerely,
Monroe County ADHD Task Force

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ADHD Best Practice Dedication

The original scope and objective of the Monroe County Best Practice ADHD Task Force began with a conference, **Attention Deficit Disorders, Medical Management • Educational Management — Fitting the Pieces Together Conference** on September 29, 1995. At the conference, 300 professionals representing both the medical and educational communities met to discuss barriers to communication for students with ADHD. The conference attendees concluded there was a pressing need for a county-wide mechanism to improve communication between home, school and health care provider for children with this disorder. This charge to the Task Force initiated the current phase of the project.

Speaking as a parent of two diagnosed children, I'd like to take this opportunity to acknowledge the dedicated core team of active participants who voluntarily stepped forward and continued to meet for the subsequent 24 months in order to see this project through to its conclusion. The following individuals met as a team in an unfunded effort to address this defined need and document their work by preparing this manual: Jo Anne Antonacci, Executive Director for Exceptional Children; Agneta Borgstedt, M.D., F.A.A.P.; Carol Criss, SETRC Training Specialist; Ellen Gellerstedt, M.D., F.A.A.P.; Harold Kanthor, M.D., F.A.A.P.; Jeanne Lally, School Counselor; Peter MacKenzie, Ph.D., School Psychologist; Joanne Mattiucci, SETRC Training Specialist; Sanford Mayer, M.D., F.A.A.P.; Nancy O'Mara, R.N., School Health Coordinator; Richard Smith, Parent.

I would like to dedicate this work not only to those who will use it as a resource for the management of children with ADHD but to the children who will be the primary beneficiaries. The initial driving force for this project was to improve the communication between all the players for the sake of our children. It is our hope that implementation of the spirit and practices herein will assist our children in achieving higher levels of academic and personal excellence and enhance the quality of their lives.

When all is said and done, the measurement of success will be the students' performance, not ours.

Richard O. Smith
Parent

Overview of ADHD Task Force History

September 1991

United States Office of Special Education and Rehabilitative Services, Office of Elementary and Secondary Education, and the Office for Civil Rights issued a joint memorandum to the Chief School Officers. This clarification of policy to address the needs of children with ADHD within general and/or special education directed states to ensure that these students benefit from their education and are afforded those services and accommodations that best meet their educational needs. Local education agencies designees' must consider supports, services, and accommodations under the Individuals with Disabilities Education Act (IDEA) or Rehabilitation Act of 1973, Section 504 to insure that these students benefit from a free appropriate public education in the least restrictive environment.

May 1992

New York State Education Department issued a field memorandum outlining the Department's position in response to the Federal memorandum. Consistent with the Federal memorandum, the State Education Department directed local education agencies to have in place policies and practices that ensure students having or suspected of having ADHD have access to referral, evaluation, and services/accommodations as guaranteed by IDEA or Section 504. Students eligible under IDEA criteria would receive special education supports or services. Students meeting eligibility as a student with a disability under Section 504 criteria would receive reasonable accommodations in their general education program.

Spring of 1993

Representatives of the State Education Department met with representatives from the educational and medical fields to discuss the needs of students with Attention Deficit Disorders in Monroe County. One perceived need was improvement of communication between health care providers and educators and a standardized approach was recommended.

October 1994

The Monroe County ADHD Task Force Committee was formed. The committee was charged with planning a conference to enhance communication between the medical community and the educational community.

Diagnostic Template For Best Practice

A. Overview of diagnosis.

The characteristics of hyperactivity, inattention, and impulsivity may result from a number of causes, not just Attention Deficit Hyperactivity Disorder (ADHD). For example, a student who is anxious or depressed may appear to be hyperactive or impulsive. Similarly, children who struggle with an undiagnosed learning disability or language disorder may share symptoms of frustration, hyperactivity or impulsivity. In other words, there are many conditions that look like ADHD. It is common for an individual with ADHD to have other problems (co-morbid conditions) that may also contribute to his or her difficulties. For example, an individual may have both ADHD and a learning disability or ADHD and anxiety. The purpose of the diagnostic process is to gain a broad understanding of the individual child and to explore all possible factors contributing to the child's difficulties.

This proposed diagnostic template recommends the areas of inquiry necessary to screen a student for ADHD and conditions that mimic and/or accompany ADHD. The recommendation for collaboration between the school component and health care provider component assumes a spirit of cooperation and division of labor. Who specifically provides a component may vary. It is important that all components be covered in this preliminary information-sharing process to assure a broad overview of the student. The process provides the student and parent with the necessary assessment by medical and school professionals, early intervention in the least restrictive environment, and avoids unnecessary or repeated diagnostic testing of the student. **Following this preliminary process, should the health care provider or school determine that a full evaluation or review by the Committee for Special Education (CSE) would be helpful, such a request should be made.**

One very important intention of this proposed process is to facilitate communication between educators, medical providers, and parents. All involved need to understand the perspective and unique contributions of each other. This document is intended to clarify these components.

We designed this diagnostic template to identify areas that may need more thorough investigation. For example, if the screen for cognitive ability does not clearly indicate at least average ability, appropriate testing needs to be done to clarify this issue.

B. School's contribution.

- **Screening for psychopathology.** Because many different conditions may mimic ADHD, it is important to obtain a broad overview of the student, including the investigation of other possible causes of behavioral difficulties commonly associated with ADHD. These may include anxiety, depression, obsessive compulsive disorders or reaction to events in the environment, (e.g., stress, victimization).

- ◊ **Achenbach Child Behavior Checklist or Behavior Assessment System for Children (BASC).** These are two broad screening instruments for psychopathology. Both have a parent, teacher, and self component. They provide a norm-referenced profile of the child and may suggest the need to look further for specific psychological conditions. These instruments also screen for attention problems and hyperactivity.

    If significant for attentional difficulty, obtain ADHD measure, e.g. Conners, ACTERS, Yale. These scales are specifically designed for Attention Deficit Hyperactivity Disorder. If the broader screening instrument, e.g. Achenbach or BASC, suggests ADHD, then these more specific instruments will add valuable information and are shorter, allowing for follow-up information to be more readily collected. Because so many conditions can mimic ADHD, these instruments alone cannot provide a sufficiently broad view of the child.

- **School observation by someone other than the teacher.** This is intended to provide information from an objective observer of the child in the school setting.
    - ◊ **Classroom and non-structured situation**. Behavior may vary widely from setting to setting in the school environment. Therefore, observation both in the structured classroom setting and in a less structured situation is recommended.
    - ◊ **Quantified data, ideally with a sample from a "non-problem" student**. The purpose of this data is to quantify the percentage of on-task behavior for the student and for a "non-problem" peer. It is generally accepted that an average student is on task approximately 80% of the time. Looking at a non-problem student may help to clarify if this is an acceptable standard in this particular classroom.

- **School history from review of folder.** A diagnosis of ADHD requires demonstration that the characteristics have been present prior to the age of seven years, are present across a variety of situations, and significantly interfere with performance. Sudden onset of characteristics or the presence of characteristics in only a limited number of settings suggest a diagnosis other than ADHD.
    - ◊ **How long have characteristics been present?** According to the school folder, has there been evidence of similar characteristics in the past?
    - ◊ **In what settings?** This would include structured settings and unstructured settings. Symptoms may vary depending on the child's interests, talents, and level of involvement.

- **A statement from appropriate school personnel concerning the student's abilities and performance (can be obtained from review of student folder).** The intention of this section is to screen for cognitive deficits, learning disabilities, and language problems. All of these can mimic ADHD and can accompany ADHD. If there is any suggestion of a problem during this screening process, further investigation of these difficulties should be pursued.
    - ◊ **School/Cognitive ability (Otis-Lennon, K-BIT, WISC-III, Stanford-Binet, Kaufman-ABC, etc.).** This is to screen for cognitive ability. Students with low cognitive ability may be very frustrated in the regular educational setting and may appear to have ADHD. There are a number of instruments that serve this purpose. Group school ability tests (such as the Otis-Lennon) are helpful in estimating a student's cognitive abilities. In the investigation of ADHD, it is not necessary that every student be tested individually. However, it is necessary that there be some clarification that the student has at least average cognitive ability. If there is any concern in this area, further investigation should be pursued.
    - ◊ **Academic performance.** This is to screen for possible learning disabilities. Again, a student with an undiagnosed learning disability may be extremely frustrated, anxious or depressed. A review of previous testing may reveal the need for further educational testing.
    - ◊ **Speech and language skills.** This is to screen for language problems that may be interfering with communication and with understanding of spoken and written instruction. Language problems can cause behavior that mimics ADHD and frequently accompanies ADHD. If there is evidence of language problems or auditory processing problems, further investigation is indicated.

- **Describe any known environmental or family stressors.** This is to screen for other factors that may be leading to maladaptive behavior (i.e., agitation, withdrawal, inattention).

- **Screen for contributing health concerns.** Concerns in this area should be addressed to the student's primary health care provider.
    - ◊ **Hearing, vision.** Sensory deficits can interfere with learning and behavior.
    - ◊ **Medications.** Side effects of some medications may include drowsiness, hyperactivity, etc.
    - ◊ **Other medical conditions.** A number of medical conditions can interfere with school progress and school adjustment. These need to be clarified as possible contributors to the student's difficulties.

C. Health care provider's contribution. One role of the health care provider as part of the diagnostic team is to look for medical conditions that can mimic ADHD or accompany ADHD. The health care provider can confirm a diagnosis and subsequently work with the student, parents, and school personnel on interventions.

- **Medical history (supplementary information from the school nurse may be helpful).** This will include a summary of the child's medical history with any possible contributory factors. Examples may include a history of prematurity with central nervous system trauma, epilepsy, Tourette disorder, medications, etc.

- **Family history.** This will include a search for learning problems, behavior problems, and psychopathology in the extended family. This knowledge may lead to further investigation for genetic components or may indicate that the child is at risk for a psychiatric disorder. A family history of violence or anti-social behavior in a student with aggressive behavior may hasten referral to mental health services.

- **Screen for conditions that mimic ADHD symptoms.** In addition to the school's screening instruments, the health care provider should ask sufficient questions to screen specifically for the following disorders: anxiety, obsessive compulsive disorder, depression, Tourette disorder, seizures, sensory deficit, post traumatic stress disorder, etc.

- **Search for associated (co-morbid) conditions.** The above conditions may co-exist with ADHD and need specific intervention.

- **Developmental screening.** Special attention should be paid to speech and language as well as fine motor development to assure that it is appropriate.

- **Physical examination.** This includes observation for dysmorphic features and a neurologic exam.

- **Review of information from school, family, and other sources.**

- **Assessment and recommendations, including need for further evaluation/consultation, medication.**

- **Communication with family and school personnel.**

Next Step: A Collaborative Intervention Model

Successful intervention for ADHD entails the collaborative efforts of family, school, and health care provider. The goal of all treatment is to make sure that the student has the skills needed for successful self-management and that the learning environment is supportive.

Useful interventions are described below:

Education about ADHD: It is important to ensure that parents, students, school personnel, and medical personnel understand ADHD, its causes and variations and current recommendations for treatment.

Developing a plan for the student: There are a variety of types of ADHD and most individuals have a combination of factors contributing to their specific difficulties. ***Therefore, there is no single prescription or intervention that works for all students with a diagnosis of ADHD.*** Successful intervention requires understanding the unique strengths and needs of the student, followed by an individual plan. All plans work best when parents, educators, and health care providers agree to the elements of the plan and have a clear understanding of who is responsible for each part. ***With each new school year, there are new professionals involved. This requires that there be ongoing collaboration and communication to assure the continuity of the intevention plan.***

Environmental modifications: These may include provisions to decrease distractions, maximize attention and encourage active student involvement.

Behavior modifications: Strategies, instruction, and/or reinforcement programs should be designed to encourage skill development and reduce the frequency of counterproductive behavior. Self-monitoring skills may be an important element.

Educational interventions: Individualized educational plans (IEPs) are designed to enhance the learning of specific skills and compensatory strategies such as organization and study skills.

Counseling intervention: This may be useful for helping the child and parents gain a clear understanding of how ADHD may be affecting student performance.
Counseling may be helpful in planning and implementing behavior management strategies. Traditional insight-oriented counseling has been shown to be ineffective as a treatment for ADHD.

Pharmacological interventions: As part of a multimodal intervention plan, medication may help the student benefit from other interventions. There are a number of medications used, depending on the target symptoms of the student. There is a great need for communication among all parties when working with medication . School personnel should be aware of a change in dosage, how long it may take to see the desired effect, and potential side effects.

KEEPING THE PROCESS ALIVE:
THE CENTRAL ROLE OF THE FAMILY

Parents and family members provide the central link and are in the best position to make sure that all the elements of the ADHD management strategies are brought together to form a complete picture. Not only are we responsible for the largest part of our children's lives, we have their individual interests in the forefront of our minds and priorities.

Children start out spending most of their time with their parents. As they enter school, they split this time between parents and teachers. As they enter middle school, the children will have to deal with several teachers, not just one. [There are usually fewer changes in the medical professionals each family chooses than teacher changes in the schools, but in our mobile society, it is likely there will be some relocation.] New doctors and teachers will have to be informed of our children's previous histories so we can build on what we've learned and achieved as opposed to "reinventing the wheel."

Our son had difficulties in his earliest school years. He spent his first and second grade frustrated because he was unable to complete schoolwork in a timely fashion, particularly homework. We asked about and created the theoretically ideal environment for study at home; quiet, no distractions, and we worked with him frequently. By the end of the third grade, the difficulties went beyond academics to a deteriorating attitude and increased level of frustration in not being able to please his teacher. [He was clearly not lazy, was clearly not flitting time away on other activities, and was clearly having difficulty keeping pace with the material.]

Our son was frequently in tears over not being able to get his work done in a reasonable amount of time and many days he didn't have time for much else. He was genuinely relieved when school broke for that summer. My wife and I just "felt" something was genuinely wrong even though he appeared to be in good health. We took him to our pediatrician and it was that doctor's recommendation that we should have him evaluated for ADHD. This was the first time we'd heard about it. There was a significant waiting period before starting the diagnostic evaluations, but we felt it would be worth it to follow through. Clearly we needed to change something.

The homework ultimately became a watershed issue in his third grade as we collaborated with his teacher and agreed to do everything we could to improve it. It turned out that his teacher gave the homework assignments verbally. As our son was writing down what he heard first, he was concentrating on that task so much he'd stopped listening until that first assignment was written down. By the time he started listening again, the teacher was on to the third item and our son had missed the second. We knew he could copy from the blackboard and books so we asked the teacher if she would write the assignments down for him. The teacher refused to alter her teaching style during class, but a compromise position was reached in which he showed her what he'd written as he walked out of the classroom. When the teacher saw there were assignments missing, she verbally repeated them until his written notes were complete. From that day on there were no more unexpected "incomplete" grades. We were able to carry this message along to subsequent teachers in later grades whenever there was a problem.

Our son was diagnosed with ADHD while he was in the fourth grade. My wife and I immediately embarked on a journey to become educated about the disorder. We consulted with our doctors and teachers, relied on their input and used their guidance and expertise to develop strategies aimed at having our son achieve higher levels of success in school. We all went through a learning curve of trial and error while we were looking for the most effective combination of interventions. We learned of and joined a local support group, GRADDA, and found not only that we weren't alone, but that there were many strategies available to set up the atmosphere for success for children with ADHD. Through the years, we've communicated frequently with all of his doctors and teachers, and continued our involvement in these vital support activities, all the while making adjustments even to this day.

As we learned more about ADHD, we were more prepared with our daughter as she entered school. She was diagnosed at an earlier age than our son because we recognized her difficulties and the need for an evaluation at an earlier age, before her difficulties manifested themselves in the higher level of frustration and emotions which we went through with our son. She was diagnosed with ADHD early in her second year of school and although the management strategies for her were quite different, the underlying principles were the same: to set her up for success. We've all since enjoyed the benefits of having a more enlightened school staff, being aware of the benefits of positive reinforcement as opposed to punishment, and making mid-course corrections well before the issues become emotional.

Attention Deficit Disorder doesn't "turn on" at 7:30 AM and "off" at 2:30 PM on Monday through Friday. It affects our children and those around them 7 days per week. One of the trademarks of ADHD is inconsistency; we know there are certain situations in which performance can be adversely affected by ADHD just as there are other situations in which it is not. ADHD is also a complex condition which must be managed over a period of years and for many individuals the symptoms continue into adulthood.

ADHD manifests itself on many fronts, some of which are medical, some educational, some familial, some social, and so on. It is therefore unreasonable to expect success by focusing on any one of these elements. I firmly believe the most effective strategies are those based on a holistic framework. There is clearly a need to coordinate education, medical, and other management strategies and to draw the applicable resources together in order for our children to be set up for success.

I am of the opinion that children can be greatly confused if they receive "mixed signals" from those around them. As an example, if a teacher is more concerned with the content of a homework assignment than the handwriting or spelling, a parent should not emphasize or criticize handwriting or spelling in lieu of content at home. If a teacher is expecting 5 math problems to be done, a parent should not be satisfied with 3. However, a parent is in the best position to know how long it takes the child to do the homework assignments and recognize when there is a problem.

The definition of academic success changes as a child grows. Expectations change. Goals change. The child's world and sphere of influence changes. Thinking processes need to grow from relying on straightforward memory, such as memorizing math tables, to developing analytical skills and learning how to apply knowledge to solving problems. We can no longer be satisfied by knowing there are one hundred cents in a dollar; we have to figure out which of the two items in the store is the better value. Our children must also learn and develop the social skills necessary to deal with more and more people and more situations as they grow and mature.

The sections preceding this one present suggested roles for medical professionals and educators. Our Task Force has presented a good case for the need for these disciplines to work together to achieve success. But like a puzzle, the pieces must be assembled and held together in order to present a complete picture. ADHD is a very complex disorder and although management strategies have common elements, there are those which may be particularly effective for any given individual. We parents are in the best position to keep track of the most effective measures for our children.

Parents are responsible to ensure their children have taken their medicine before going to school if such has been prescribed. Some medications must be taken during school hours. It is not appropriate for teachers to give out meds, but teachers can ensure the student remembers to go to the nurse at the appropriate time. There may be social consequences of having the child break away from the class to go to the nurse. If this is a significant problem, perhaps the parent can ask the doctor to consider single dose, longer-acting medications.

Parents and teachers must provide input to the medical professionals regarding student performance. The doctors can assess whether changes in the medical strategy may be required only if they receive proper feedback.

Expectations and medical management may be adjusted as the needs of the children warrant. It is therefore necessary to maintain a line of open communication regarding the children's medical, educational, and home life. When our collective antennae are up and we're all tuned in, appropriate adjustments can be made in timely fashion.

Parents are also responsible for supervising their children's lifestyle to assure they get adequate rest and exercise, and balance the priorities of academic and social life. Management of these "home and family" aspects can result in either significantly positive or counter-productive effects. Again, I believe the parents are in the best position to assure the children stay on track.

It is the responsibility of the family to create a good study environment at home for doing homework. If the children need additional help to understand what's being presented in class, there may be a need to stay after school, or secure a tutor or a notetaker. Parents working with teachers and other school staff can address these needs.

Teachers have many students. Doctors have many patients. We parents are in the best position to offer support to our children. Management of ADHD clearly involves at least three areas—home, school, physician—working together.

My wife and I have been proud to display the bumper stickers our children earned for their academic successes. Both worked their way from needing lots of extra support to gain passing grades, to achieving average grades, and ultimately onto the High Honor Roll. Our kids certainly didn't do it themselves, though. They were at first given, then earned, the support and respect of all those around them. It works!

Richard Smith, Parent

Model Forms For Communication

- Cover letter to the principal
- Consent for release of information
- Physician's request for information
- Physician's summary of medical assessment and recommendation
- Permission to administer medication

(Forms may be reproduced)

COVER LETTER TO BE PUT ON PHYSICIAN'S LETTERHEAD

Cover Letter to Principal

Student's Name _____ Date of Birth _____

Date: _____

Dear Principal of _____ School,

The above student is being evaluated for a possible school-related problem. In order to contribute to a comprehensive assessment for this child, I'm asking you to send the information as requested on the attached form. For your convenience, I've enclosed a consent form signed by the parent.

Thank you for working with me for the benefit of this child.

Sincerely,

_____, Physician

PHYSICIAN'S USE ONLY

Medical Record No. _____

FORM TO BE PUT ON PHYSICIAN'S LETTERHEAD

Consent for Release of Information

I hereby give permission to school personnel to release written and verbal information on_____ to Dr. _____ at
(Child's Name)

_____.

I also give permission for my child's school to receive medical information from the above-named physician.

_____ _____
Signature of Parent or Guardian Witness

_____ _____
Printed Name Today's Date

Physician's Request for Information

Student's Name_____ Date of Birth_____

PLEASE RETURN THIS FORM ALONG WITH REQUESTED INFORMATION TO:

_____

_____

_____

Fax: _____

Best way to reach me: _____

_____ A description by the student's teacher or other school personnel of any problem related to academic progress or classroom behavior.

_____ Description of current classroom setting (type of class, teacher:pupil ratio, etc.)

_____ Any current additional resources provided? ___ Yes ___ No Please clarify:
_____

_____ Has school team evaluated this student? ___ Yes ___ No If yes, please send a copy of the report. If no, is an evaluation planned? ___ Yes ___ No

_____ Academic achievement test results.

_____ Report cards from current and previous years.

_____ Has psychological testing been done? ___ Yes ___ No If yes, please send a copy of the report.

_____ Rating forms: I prefer to use: _____ Conners teacher questionnaire
_____ Yale form
_____ Child Behavior Checklist (Achenbach)
_____ Other form (copy enclosed)

(Does school need copies of forms to be used? ___ Yes ___ No)

_____ Teacher description of classroom behavior.

_____ Current school interventions.

_____ Any other information that the school may believe to be helpful.

_____ Additional information as stated.

Name of contact person preferred for physician communication, phone number, and preferred contact time. _____
_____

Thank you for your assistance!

Physician's Summary of Medical Assessment & Recommendation

DATE:_____

Student's Name _____ D.O.B. _____
School _____
Physician _____
Physician's Phone# _____ Best Time to Call_____
Other _____
(i.e., voice mail, fax)

I have reviewed:

___ Medical History
___ Educational History
___ Physical Examination
___ Testing
___ Family History
___ Behavioral History
___ Psychosocial History

Working Medical Diagnosis:

Possible Co-morbidities?:

Medical Plan:

___ Considerations that may be useful:

___ Referral for outside counseling or further medical evaluation:

___ Initial Medication Trial?
___ Yes ___ No If yes, see order form.

___ Parent/Student education re: diagnosis:

<u>Follow-up Plan/Recommendations</u>:

___ By Physician: _____

_____

<u>Recommended follow-up</u>:

___ From School: _____

_____

___ From Parent: _____

_____

Thank You! _____
Signature

Prescriber's Authorization for Administration of Medication in School

I request that my patient, as listed below, receive the following medication:

Name of Student:_____ Date of Birth:_____

Diagnosis:_____

Medication:_____

Dosage (specific amount to be given each dose):_____

Route of Administration:_____

Time to be taken during school hours:_____

Possible Side Effects/Adverse Reactions:_____

_____

_____

Intended Effects:_____

_____

_____

For PRN medication, conditions under which to administer:_____

_____

Other Medications being taken (at home):_____

_____

Name of Licensed Prescriber/Title: (please print) _____

Prescriber's Signature:_____ Date:_____

Address:_____ Phone:_____

Please Return Form to:

Glossary

Glossary of Educational Terms

This glossary includes a variety of terms or words
that are often used in the school setting.

Achievement Test: A test that measures a student's level of development in academic areas such as math, reading, and spelling. Scores are usually given in comparison to national samples of other students at a grade level (i.e., grade equivalent), age level (i.e., age equivalent) or as a percentile rank for students in the same age/grade group. (i.e., 50th percentile is average for any given group.)

Annual Goal: Statement describing the anticipated growth in a student's skill and knowledge written into a student's yearly Individualized Education Program (IEP).

Annual Review: A yearly review of a student's Individualized Education Program (IEP) and the development of a new IEP for the next year.

Audiologist: A licensed non-medical specialist who measures hearing levels and evaluates hearing loss.

Auditory Discrimination: The ability to identify and distinguish among different speech sounds; e.g., the difference between the sound of "a" in say and in sad.

Central Auditory Processing Disorder: A delay in the ability to use and understand auditory information in a meaningful way in the absence of what is commonly considered a hearing loss. A central auditory processing disorder is identified through the administration of dichotic listening measures at prescribed loudness levels in an otherwise controlled environment.

Cognitive: A term describing mental processes such as attention, memory, judgment, and reasoning.

Committee on Special Education (CSE)/Committee on Preschool Special Education (CPSE): Multidisciplinary teams that review all materials and determine the eligibility of students for special education services and the services to be provided. This includes the development and approval of educational goals and objectives.

Communication Disorder: A general term for any language and/or speech delay or deficit.

Confidential File: A file having restricted access and containing records of a child's evaluation and other materials related to special education (medical reports, independent evaluations, reports of eligibility meetings, etc.). Access is restricted to professionals within the educational setting who are working directly with the student. Parents have the right to review their child's confidential file in school.

Confidentiality: As used in the educational setting, confidentiality is the limiting of access to a child's school records to his/her parents and to school personnel having direct involvement with the child as covered in the Buckley Amendment.

Consent: Consent refers to parental permission initially needed to evaluate a child or to place a child in a special education program.

Cumulative File: A file containing report cards, standardized achievement test scores, teacher reports, and other records of a student's school progress.

Developmentally Delayed: Term used to describe an infant or child whose development is slower than expected in one or more areas of development.

Developmental Disability (DD): Any severe disability, mental and/or physical, which is present before an individual becomes eighteen years old, which substantially limits his/her activities, is likely to continue indefinitely, and requires lifelong care, treatment, or other services. Examples of developmental disabilities include Down's syndrome, autism, pervasive developmental disorder and cerebral palsy.

Educational Diagnostician: A professional who is certified to conduct educational assessments and to design instructional programs for students.

Emotionally Disturbed (ED): Term used to describe individuals whose behavior is considered inappropriate, excessive, chronic, or abnormal. Educationally, children who are ED have difficulty learning/establishing satisfactory relationships with others and behaving appropriately.

Expressive Language: The ability to communicate through speech, writing, or gestures.

Evaluation: The process of obtaining detailed information about a student's educational needs through a series of tests (academic, performance, psychological, etc.) and observations. May also be called assessment.

Fine Motor Skills: Body movements which use small muscles; for example: stacking blocks, tying shoes, or writing in cursive.

Gross Motor Skills: Body movements which use large muscles; for example: walking, running, or throwing a ball.

Individuals with Disabilities Education Act (IDEA): Reauthorization of P.L. 94-142 which mandates free, appropriate public education for all children and youth with disabilities.

Independent Evaluation: An evaluation/assessment of a student conducted by a professional not employed by the school system.

Individualized Education Program (IEP): A written statement for each student in special education describing his/her present level of performance, annual goals including short-term objectives, specific special education and related services the student is to receive, dates for beginning and duration of service, and how the IEP will be evaluated.

Intelligence Quotient (IQ): A measurement of thinking (cognitive) ability for comparison of an individual with others in his/her age group.

Learning Disability (LD): A disorder in one or more of the processes involved in understanding or using language, spoken or written, resulting in difficulty with listening, thinking, speaking, writing, spelling, or doing mathematical calculations. This term does not include children with learning problems related to other disabilities such as mental retardation.

Learning Style: An individual's preferred way of learning, for example, by reading a book, listening to a lecture, handling materials. Most people learn best through a combination of processes.

Least Restrictive Environment (LRE): Placement of a student with disabilities in a setting that allows maximum contact with non-disabled students, while appropriately meeting all of the student's special education needs.

Mediation: A formal intervention between parents and school systems to achieve reconciliation, settlement, or compromise in a dispute over educational services.

Multidisciplinary Evaluation: The testing of a child by a group of professionals: psychologist, special education teacher, reading teacher, speech and language therapist, physical and/or occupational therapist, etc.

Multidisciplinary Team: A group of educational professionals: usually including psychologist, special education teacher, the child's classroom teacher, speech and language therapist, administrator, school counselor, etc.

Objective: An objective is a short-term step taken to reach a long range goal. IEP objectives are benchmarks between a student's present level of performance and an annual goal.

Other Health Impaired (OHI): Term used to describe conditions which adversely affect a child's educational performance that is not covered by other disability definitions (e.g., Learning Disabilities, Mental Retardation, etc.). This term is frequently used for various medical conditions such as a heart condition, diabetes, cystic fibrosis, leukemia, ADHD, Tourette syndrome, etc.

Psychological Evaluation: The portion of a child's overall evaluation/assessment which tests his/her general intelligence, eye-hand coordination, social skills, emotional development, and academic achievement.

Reasonable Accommodation: The modification of programs in ways that permit students with disabilities to participate in educational programs which receive federal funding. The concept also applies to the modification of job requirements for workers with disabilities.

Receptive Language: The process of receiving and understanding written or spoken language.

Referral: A formal notification to the local school that a child is experiencing educational difficulties and may need a full evaluation for special education.

Related Services: Those services a student must receive to benefit from special education (i.e., transportation, occupational therapy, speech therapy, counseling, and nursing services).

Section 504 (Rehabilitation Act of 1973): Section 504 affirms a child with a disability's right to a free, appropriate public education and stipulates that individuals may not be excluded from participating in programs and services receiving federal funds because they are disabled. It also prohibits job discrimination against people with disabilities.

Speech Impaired (SI): A disorder involving an impaired ability to comprehend or effectively communicate through language, including articulation difficulties.

Speech Therapy: Activities or routines designed to improve and increase verbal communication and comprehension skills.

Transition: The process of moving from one situation to another. Transition can be used to mean moving from preschool programs into elementary school, from middle school to high school or from school to work and the community.

Transition Planning: At age 14 it is required that transitional goals be developed as part of a student's IEP to help plan for life after high school.

Triennial Review: Every three years, a student in special education is re-evaluated to determine educational progress and achievement, the ability to participate in instructional programs in regular eduation, and eligibility for continued special education services.

Adapted from:

Anderson, W., Chitford, S., & Hayden, D. (1990). Negotiating the special education maze: A guide for parents and teachers. Woodbine House, Inc.

Selected Bibliography

Selected Bibliography

Armstrong, Thomas (1995). The myth of the A.D.D. child, 50 ways to improve your child's behavior and attention span without drugs, labels or coercion. Dutton/Penguin Books, Ltd.

Barkley, Russell A. (1997). Defiant children: A clinician's manual for assessment and parent training, second edition. New York, NY: Guilford Press.

Barkley, Russell A. (1995). Taking charge of ADHD: The complete, authoritative guide for parents. New York, NY: Guilford Press.

Barkely, R. A. (1990). Attention-deficit hyperactivity disorder: A handbook for diagnosis and treatment. New York, NY: Guilford Press.

Fowler, Mary Cahill (1990). Maybe you know my kid: A parent's guide to identifying, understanding, and helping your child with attention-deficit hyperactivity disorder. Secaucus, NJ: Carol Publishing Group.

Hartman, Thom (1993). Attention deficit disorder: A different perspective. Underwood Books.

Hallowell, Edward M., & Ratey, John J. (1994). Answers to distractions: Recognizing and coping with attention deficit disorder from childhood through adulthood. New York, NY: Random House, Inc.

Ingersoll, Barbara D. (1988). Your hyperactive child: A parent's guide to coping with attention deficit disorder. New York, NY: Doubleday.

Ingersoll, Barbara D. (1993). Attention deficit disorder and learning disabilities: Realities, myths, and controversial treatments. New York, NY: Doubleday.

Kelly, Kate, M. (1993). You mean I'm not lazy, stupid or crazy?!: A self-help book for adults with attention deficit disorder. Cincinnati: Tyrell & Jerm Press.

Kennedy, Patricia (1993). The hyperactive child. New York, NY: St. Martin's Press.

Levine, Mel (1994). Educational care: A system for understanding and helping children with learning problems at home and in school. Massachusetts: Educators Publishing Service, Inc.

Rief, Sandra F. (1993). How to reach and teach ADD/ADHD children: Practical techniques, strategies, and interventions for helping children with attention problems and hyperactivity. West Nyack, NY: Center for Applied Research in Education.

Silver, Larry B. (1993). Dr. Larry Silver's advice to parents on attention-deficit hyperactivity disorder. Washington, DC: American Psychiatric Press.

Articles

"Children Who Have Attentional Deficit Disorder: Diagnosis and Evaluation." **Pediatrics in Review**, December 1993, Vol. 14, N. 12, p. 455.

"Guides for Records Review. Attention Deficit, Hyperactivity Disorder." Supplement to **Pediatrics in Review**, February 1995.

"Staying Focused: Documenting the Management of a Child Who Has an Attentional Disorder." **Pediatrics in Review**, February 1995, Vol. 16, N. 2, p. 75.

Videos

Barkley, Russell A. (1994). **ADHD in adults.** Guilford Press, Inc., 72 Spring Street, New York, NY 10012.

Barkley, Russell A. (1994). **ADHD in the classroom.** Guilford Press, Inc., 72 Spring Street, New York, NY 10012.

Barkley, Russell A. (1992). **ADHD: What do we know?** Guilford Press, Inc., 72 Spring Street, New York, NY 10012.

Barkley, Russell A. (1992). **ADHD: What can we do?** Guilford Press, Inc., 72 Spring Street, New York, NY 10012.

Phelan, Thomas W. (1990). **All about attention deficit disorder. Part II Diagnosis and treatment.** Child management**,** Inc., Carol Stream, Illinois.

Periodicals

ADHD Alert, Division of Child Neurology, A Quarterly Newsletter Sponsored by the Division of Child Neurology, Virginia Commonwealth, Division of Child Neurology, MCV Box 989211, Richmond, VA 23298.

The ADHD Report, edited by R. A. Barkley, Guilford Press, 72 Spring St., New York, NY 10012; telephone (800) 365-7006.

Web Sites

Children and Adults with Attention Deficit Disorder (CHADD) is a nationwide organization which has an extensive network of support groups. CHADD also publishes a magazine and sponsors an annual International Conference on ADD. **http:// www.chadd.org**

The Learning Disabilities Project at WETA, Washington DC in association with The Parents Educational Resource Center and The Coordinated Campaign for Learning Disabilities. **http://www.ldonline.org**

National Institute of Mental Health. This site contains an extensive booklet published by NIMH. **http://www.nimh.nih.gov/publicat/adhd.htm**

Mental Health Network has an excellent overview of ADD with case study examples. **http://www.cmhcsys.com/guide/adhd.htm**

One ADD Place is a collection of items of varied areas of interest including events, products/services, resources and library references. **http://www.greatconnect.com/ oneaddplace.htm**

National Attention Deficit Disorder Association (ADDA). This organization focuses primarily on adults with ADD. **http://www.add.org**

Nemours Foundation for Biomedical Communication. Good introduction of the ADD topic and co-morbid conditions. **http://kidshealth.org/parent/behavior/adhd.html**

Greater Rochester Attention Deficit Disorder Association (GRADDA) serves the Greater Rochester, New York area. It has monthly support groups for adults, parents, and children in grades 7 through 12, an extensive library, bookstore, and quarterly newsletter. **http://www.netacc.net/~gradda**