STRATEGIES FOR SUCCESSFUL RE-ENTRY OF STUDENTS WITH TBI TO SCHOOL

This model has the framework of a gradual shift of leadership/responsibility from the medical facility to the educational facility. The medical facility takes leadership from the point of admission to discharge, with the educational facility taking on growing responsibility as the student nears discharge. At the point of discharge, the educational facility takes leadership with the medical facility taking more of the supportive role. At all points of the process, the family should be informed and involved as much as possible. Some families will choose to take leadership in planning the child's return to school; other families will rely on professionals to provide leadership. In all cases the family should be provided the name of their contact person in both settings.

MEDICAL FACILITY	EDUCATIONAL FACILITY
Initially	**Initially**
Identify school and medical contact	Designate school contact person
Collect records of child's pre-injury status, school materials	Obtain parent permission to share information with medical facility
Obtain consent/release of information	Determine relevant records to share; provide to medical facility
Establish if child received special services and if so, what?	
Establish parameters of child's former school day, routines and curriculum	Provide information re: schedule, curriculum, routines
Provide preliminary information on TBI, child's status and possible outcomes	Collaborate with medical facility to determine program and services needed
During Hospitalization	**During Hospitalization**
Provide regular updates on progress	Review and share updates with school staff
Provide in-hospital educational support	Provide relevant materials & assignments (if child is able to work on school work)
Arrange for school/hospital on-site visits for key school and medical staff	Coordinate on-site visits at school level
Assess physical layout of home and school for potential barriers	Share task of assessment of school environment
Determine need and plan for in-service training, consultation and peer preparation	Determine need and plan for staff training, consultation, and peer preparation
Prepare school for projected re-entry time-frame	Assure all elements necessary in the school environment are in place
Educate family about special education process, rights, re-entry plan, child's projected services needs	Educate family about special education process, rights, re-entry plan, child's projected services needs
Conduct multidisciplinary assessment at Rancho Level VI and/or 3-4 weeks prior to discharge from facility	Participate in assessment process and share information
Refer for special education services, if appropriate	Refer for special education services, if appropriate

Medical Facility	Educational Facility
During Hospitalization (cont.)	**During Hospitalization (cont.)**
Forward medical, psychological, educational, sociocultural and specialized therapy evaluation summaries 2-3 weeks prior to anticipated discharge. Provide information (written, oral, phone conference, videotape) of recommended behavioral management, therapeutic and instructional techniques	Share information from the medical facility with relevant staff members
Prior to Discharge	**Prior to Discharge**
Role play anticipated social scenarios with child in preparation for re-entry. Simulate school environment	Provide information to medical facility to assist with preparatory activities
Collaborate with school on providing identified in-service training, consultation and peer preparation	Collaborate with medical facility on providing identified in-service training, consultation and peer preparation
Offer to participate in school's eligibility and IEP meeting	Convene and coordinate IEP meeting, involving medical facility staff
Establish post-entry contacts and discuss availability of community resources	Facilitate contact with medical facility, involving family
Establish follow-up and re-evaluation schedule	Provide summary information for follow-up and re-evaluation

Adapted in part from objectives developed by Begali (1992, 1996)
Lorraine Henning, School Social Worker, CESA 10
Member, CESA 12 TBI Task Force
1/98

TBI TRANSITION TO SCHOOL CHECKLIST

Student:____________________________ Grade:_________ Date of Injury:_____________

School:_____________________________ Current Date:__________________

I. Prior to the Student's Return to School

A. _____ Accept or begin referral for IEP team evaluation.

B. _____ Establish school contact person and identify a special education teacher that has had "recent training or experience" in traumatic brain injury as a team member.

C. _____ Identify medical facility contact person.

D. _____ Obtain parent signature on the release of information form.

E. _____ Provide relevant school records to medical facility.

F. _____ Access current medical information.

G. _____ Attend or request information from medical update conferences. (Identify physical, cognitive, communication, medical, and social needs that may interfere with learning and social activities at school.).

H. _____ Share medical information with appropriate school staff.

I. _____ Visit student in medical facility.

J. _____ Share information with family about school re-entry and special education.

K. _____ Determine school staff and student in-service needs.

L. _____ Attend discharge planning meeting at the medical facility.

M. _____ Complete IEP team process to determine whether the student meets disability criteria prior to school re-entry when possible but at least within 60 days of receiving parental consent or providing notification to parents that no additional data is needed.

N. _____ Develop an IEP and offer educational placement within 30 days of the eligibility IEP meeting.

O. _____ Check on needs of the student's siblings in school.

II. After the Student's Re-entry

A._____ Continue on-going communication with family.

B._____ Maintain communication with all service providers (private therapists, etc.).

C._____ Set up a system to monitor progress (e.g., monthly student progress meetings).

D._____ Develop peer support system.

E._____ Prepare a proactive response to situations that may be encountered (schedule changes, field trips, etc.).

TRANSITION CHECKLIST (for use after student returns to school)

Student:_____________________________ Grade:_________ Date of Injury:_____________

School:______________________________ Current Date:__________________

The process of transition for students with TBI includes transition back to school after injury, transition between classes, grades, and schools; and transition to post-secondary education, work, and residential settings. Be sure you are addressing ALL the transition needs of students.

I. Transition Between Classes

A. _____Be sure the student has the mobility necessary to travel between classes.

B. _____Provide appropriate supervision as the student changes classes.

C. _____Ensure that all teachers understand the abilities/needs of student.

D. _____If helpful, allow the student to leave class a few minutes early or late to get to the next class.

II. Transition Between Grades and Schools

A. _____Carefully consider the needs of the student when assigning teachers, schedules, and class locations.

B. _____Consult parents in planning the student’s transition.

C. _____Be sure all teachers are aware of the needs of the student.

D. _____Allow the student to become familiar with the new setting in advance.

E. _____Provide opportunities for the student to interact with new teachers before the transition.

F. _____If helpful and feasible, implement transition gradually, so that student maintains contact with familiar people and places.

III. Transition Planning for Post School Settings

A. _____Beginning at age 14 identify courses needed (e.g., vocational, advanced placement) and needed services in:

_____instruction
_____related services for transition
_____community experiences
_____development of employment objectives
_____other post school adult living objectives
_____acquisition of daily skills if appropriate
_____functional vocational evaluation if appropriate

*Remember that there are also specific transition requirements under IDEA for Birth to Three/Early Childhood special education.

*See DPI Special Education Team’s Web address: **http://www.dpi.wi.gov/sped/transition.html** for information on post school transition.

Wisconsin Chapter 115.78

115.78 Individualized education program team; timeline. **(1)** DEFINITION. In this section, for a child who is attending a public school in a nonresident school district under s. 118.51 or 121.84(1)(a) or (4), "local educational agency" means the school board of the school district that the child is attending.

(lm) APPOINTMENT OF TEAM. The local educational agency shall appoint an individualized education program team for each child referred to it under s. 115.777. Each team shall consist of all of the following:

(a) The parents of the child.

(b) At least one regular education teacher of the child if the child is, or may be, participating in a regular educational environment.

(c) At least one special education teacher who has recent training or experience related to the child's known or suspected area of special education needs or, where appropriate, at least one special education provider of the child.

(d) A representative of the local educational agency who is qualified to provide, or supervise the provision of, special education, is knowledgeable about the general education curriculum and is knowledgeable about and authorized by the local educational agency to commit the available resources of the local educational agency.

(e) An individual who can interpret the instructional implications of evaluation results, who may be a team participant under pars. (b) to (d) or (f).

(f) At the discretion of the parent or the local educational agency, other individuals who have knowledge or special expertise about the child, including related services personnel as appropriate.

(g) Whenever appropriate, the child.

(h) If the child is attending a public school in a nonresident school district under s.118.51 or 121.84(1)(a) or (4), at least one person designated by the school board of the child's school district of residence who has knowledge or special expertise about the child.

(2) DUTIES OF TEAM. The individualized education program team shall do all of the following:

(a) Evaluate the child under s. 115.782 to determine the child's eligibility or continued eligibility for special education and related services and the educational needs of the child.

(b) Develop an individualized education program for the child under s.115.787.

(c) Determine the special education placement for the child under s. 115.79.

Common Medications Students with TBI May Be Taking When They Return to School and Their Side Effects

I. Children who have experienced TBI are most commonly discharged with medications to control seizures and spasticity. A description of the most common medications used for these purposes and their side effects follows:

Seizures. There are several antiepileptic or anticonvulsive medications that are used to treat seizures. The following table lists anti-seizure medications and their side effects:

Medication	Possible Side Effects
Depakene (valproate, valproic acid) Depakote (divalproex sodium)	Nausea, vomiting, diarrhea, constipation, restlessness, irritability, hair loss, trembling of hands or arms, weakness, drowsiness, dizziness
Dilantin (phenytoin)	Nervousness, constipation, excess hair growth, thickening of lips, loss of appetite, nausea, vomiting, drowsiness, dizziness
Klonopin (clonazepam)	Dry mouth, nausea, vomiting, diarrhea, constipation, drowsiness, dizziness, clumsiness, trouble concentrating, blurred vision, headache, "hangover" effects
Lamictal (lamotrigine)	Drowsiness, dizziness, headache, upset stomach, nausea, nervousness
Neurontin (gabapentin)	Drowsiness, dizziness, blurred vision or rapid eye twitching, poor muscle control, loss of appetite, nausea, vomiting, nervousness, weight gain
Tegretol (carbamazepine)	Nausea, headache, rash, drowsiness, dizziness, clumsiness, blurred vision,
Valium (Diazepam)	Blurred vision, "hangover" effects, drowsiness, dizziness, nausea, vomiting, difficulty urinating

Note. Medications are listed by their brand name, followed by their generic name in parentheses.

Spasticity. The most common medication used with children with TBI to reduce or prevent spasticity is called **baclofen** (brand name **Lioresal**). Baclofen is a muscle relaxant and can be administered through a pump implanted under the skin directly to the spinal fluid (called *intrathecal baclofen therapy*).

Possible side effects from the use of baclofen include:

- Rash or itching
- Chest pain or irregular heartbeat
- Bloody urine
- Tremors or seizures
- Slurred speech
- Nervousness, dizziness, or drowsiness
- Loss of appetite or weight gain
- Frequent urination
- Upset stomach, nausea, diarrhea
- Headache
- Trouble sleeping, depressed mood
- Weakness, tiredness

II. Issues to Consider with Students on Medication at School

- Physical, cognitive, and emotional side effects
- Administration of medication in school
- Duration of medication effects

Note: For further information contact a physician or school nurse.

Brian McKevitt, 7/99

Issues Related to Students with Special Health Care Needs in the School

Students with complex medical conditions and nursing/health care needs are currently seen in increasing numbers in schools. As a result, schools are providing a variety of health and nursing services to these students. Both federal and state legislation is in place to guide health care professionals in the schools.

Points to Remember:

- **Every student who has a special health care need requiring nursing care, intervention or supervision should have a Health Care Plan* written by a health care professional.**
- **In addition to a Health Care Plan, documentation should be kept on Emergency Information (emergency, EMT and ambulance numbers, hospital preference, primary physician), and an Emergency Plan and Physician's Orders for Health Care Procedures should be readily available.**
- **School personnel who are responsible for the education and care of students with special health care needs should receive training from persons who are certified or licensed to perform the procedures being taught.**
- **Health care procedures should be performed by qualified personnel who have had child specific training in the procedure.**
- **Documentation of training and on-going supervision should be provided by a health care professional**
- **A daily log which documents the procedure, date, time and observations should be completed after each procedure.**

As paraphrased from the Nurse Practice Act, Wisconsin Statues Chapter 44.11 (4) definition: The performance of nursing acts may be delegated to licensed practical nurses and/or less skilled assistants. Only a licensed registered nurse can delegate nursing procedures.

* State and federal statutes provide specific protections to students and parents regarding the maintenance and sharing of confidential student information. In general, records relating to the health of a child that contain such information as diagnoses, opinions, and judgments made by a health care provider are considered "patient health care records." The Department of Public Instruction (DPI) recommends patient health care records be maintained separately from other pupil records, because the requirements relating to access to and disclosure of information from patient health care records are more restrictive than the requirements for other pupil records.

If you need additional information related to student records and confidentiality, a publication entitled "Student Records and Confidentiality" is available electronically at: http://www.dpi.wi.gov/sspw/pdf/srconfid.pdf.

INDIVIDUAL HEALTH SUMMARY
FOR STUDENT WITH TRAUMATIC BRAIN INJURY

Student Information

Name:____Date of Birth:__________Age:________
Parent/Guardian:____Address:___________________________
Home Phone:____Work Phone:________________________
Emergency Contact:_____________________________________Phone:_____________________________
School:____Grade:_____________________________
Date of Injury: ____Current Date:______________________

Emergency Health Care Providers

Name:____Phone:_____________________________
Name:____Phone:_____________________________
Name:____Phone:_____________________________

Does this student require an emergency crisis response plan? Yes__ No__
(If yes, attach a copy to this summary.)

Does this student have a current health care plan on file? Yes____ No____ Location:_________________

Medical History: (description of injury, including area(s) affected, length of loss of consciousness and post-traumatic amnesia, and other relevant health information; DO NOT include diagnoses, judgements and opinions made by a health care provider.)

____
____
____
____
____
____

Current Functioning:

Physical Status:____
____
____
____
____
____

Psychological/Behavioral Information:____
____
____
____
____
____

Academic Functioning:____
____
____
____
____

Page 2: Individual Health Summary
Student Name:___________________________________

Does the student require special health care procedures? Yes___ (if yes, complete the following) No___

Procedures	Person Responsible	Frequency and Location

Are there current medications administered at school? Yes___ (if yes, list below) No____

Purpose of medication	Person responsible	Frequency

Does the student have special dietary needs? Yes___ (if yes, describe below) No___

____
____
____

Does the student have activity restrictions? Yes___ (if yes, describe below) No___

____
____
____

Does the student have adaptive equipment needs? Yes___ (if yes, describe below) No___

____
____
____

Does the student have special transportation needs? Yes___ (if yes, describe below) No___

____
____
____

This summary prepared by: [Name(s) & Title(s)] ______________________________
____
____
____

Definitions and Examples of Common Motor Deficits

Physical Deficit	**Definition**	**Example**
Apraxia	Inability to initiate, sequence, and execute purposeful motor activities.	The student may have trouble figuring out how to get from one position to another or from one place to another.
Ataxia	Difficulty coordinating movements, especially with injuries of the cerebellum.	Difficulty with postural control in sitting or standing position. The student may exhibit increased body sway, staggering with walking, or tremors in arms or legs.
Coordination problems	Difficulty performing smooth, controlled motor movements. This is often seen with activities that require use of both hands at the same time or arms and legs simultaneously.	Difficulty catching a ball with one or both hands or kicking a ball. Difficulty with precise hand movements for eating or writing.
Paresis or paralysis	Muscular weakness or loss of voluntary movement.	Inability to walk, write, or care for himself or herself.
Orthopedic problems	Injury to the muscles, bones, or joints in the body.	Fracture to a leg will affect the student's mobility and activities of daily living.
Spasticity	An abnormal amount of increased muscle tone, which interferes with voluntary movement.	Difficulty bending or straightening the arms and legs makes positioning difficult. Independent functional movement is difficult, particularly fine movement.
Balance problems	Inability to maintain body posture while walking, standing, or performing an activity.	The student may have difficulty walking safely in crowded hallways or lunch rooms.
Impaired Speed of Movement	Inability to perform movement with speed and precision.	Difficulty on timed motor tests. Problems with sorting, sequencing, and organizing activities in a timely manner.
Fatigue	Decreased endurance for daily activities.	Student may be able to walk independently but needs a wheelchair for long distances or rest periods during the day.

Reprinted with permission from Corbett and Ross-Thomson (1996)

Common Cognitive-Communication Deficits after TBI

Deficit	Example of Behavior
Executive functions	• lack of initiative • reduced anticipation • difficulty planning to reach goals
Memory	• forgets belongings, assignments • can't store and retrieve new information efficiently • asks same questions every day • remembers what was learned before injury, but has difficulty learning new concepts and skills
Information processing	• unable to follow lengthy or rapid instructions • slow to respond
Sequencing	• tells stories with events out of order • has difficulty following own daily schedule • starts in the middle of a task
Comprehension of abstract language	• has difficulty detecting inferences, double meanings, humor
Word retrieval	• uses vague referents and fillers (such as, "um, you know, that thing")
Expressive language organization	• stories lack cohesiveness • rambles, is tangential
Pragmatics	• doesn't read listener cues • has limited repertoire of topics, responses
Problem solving	• can't identify salient features of a problem • solutions may be related but not on target • thinks concretely
Attention, concentration	• easily distracted • overloads quickly • loses place when reading • has difficulty staying on task • misses parts of instruction

Adapted from Corbett and Ross-Thomson (1996)

MONTY

Monty has returned to his first grade classroom. During the first few weeks after his return, his teacher was pleased with Monty's progress. He seemed able to do many of the academic tasks he had mastered before the accident. For example, he could add and subtract single digit numbers, and his behavior wasn't a problem! Most of the time he was quiet, and the teacher had to encourage him to complete activities. The teacher was a little puzzled with his reading; he seemed to skip some words, especially when a sentence continued on the next line, but she figured that would take care of itself.

Now the teacher is concerned because she feels Monty is too dependent on her. She thinks Monty should be showing more initiative in completing class activities, and she is becoming irritated with his "dawdling." When Monty finally does start working on something, he won't quit and move on to the next activity. Furthermore, the teacher has noticed that the other students are tired of waiting for Monty to get in the lunch line, get ready for recess, and do his share in small group activities.

His teacher is also frustrated because Monty has been slow in learning two-digit addition. She thought it would be easy for him because his math skills were so good before the accident. She wonders if he is just trying to get her attention by working slowly, doing problems over and over, and getting the answers wrong. She has reminded him again and again to do all the problems on the page, but he often skips some problems on the left side of his papers.

1. What possible difficulties might be limiting Monty's performance in school?

2. What evidence do you see that NEW learning is difficult for Monty?

3. How might the teacher misinterpret Monty's school performance?

Social-emotional Deficit	Examples of Behavior: The student
Irritability	• Is easily annoyed by small things • Is easily provoked
Impulsivity	• Blurts out answers • Takes others' materials
Disinhibition	• Is immodest • Uses inappropriate language
Perseveration	• Continues working on the same drawing, over and over • Repeats responses
Emotional lability	• Laughs and or cries easily • Changes emotions quickly
Insensitivity to social cues	• Continues talking when people are no longer listening • Gets into others' personal space even though they back away
Anxiety	• Gets more nervous or worried about things than other students • Can't perform some tasks because of worry or nervousness
Withdrawal	• Sits in the back of the room alone during small group work • Eats alone in the cafeteria
Egocentricity	• Doesn't want to share materials • Always has to be first
Denial of deficit/lack of insight	• Refuses help because thinks it is unnecessary • Can't understand why treated differently
Depression	• Appears sad, tearful, unhappy • In adolescents, may act out
Low frustration tolerance	• Gets angry when having difficulty with a task • Gives up if work is even a little challenging

Adapted from Corbett and Ross-Thomson, 1996

SERENA

Serena has returned to her seventh grade class. The IEP team has planned many accommodations for her, and they seem to be working well overall, but the the IEP team is meeting to discuss some difficulties Serena's teachers are having.

One problem Serena's general education teacher is having is that Serena can't seem to wait for anything. She is impatient about getting help when she needs it, and she has to be first in everything – from getting in the cafeteria lunch line to getting a paper back in class. The teacher has told her again and again that she can't always be first, but the teacher says Serena insists on being first anyway. One day the teacher said to another teacher "I've told Serena over and over again that she has to wait her turn, but she doesn't. I think she's getting spoiled by all the special arrangements we have made for her."

Serena's special education teacher is having difficulty getting Serena to come with her for individual instruction in math. Serena says the work is "babyish" and she already knows how to do it. When the teacher is successful getting Serena started on an assignment, Serena may only work for two to three minutes before quitting and saying, " I can't do this. There's something wrong with these problems. And I did this in fourth grade." The other students in the resource room think Serena is funny because sometimes she uses inappropriate language.

1. What social-emotional deficits might contribute to Serena's difficulties?

2. What other deficits might also contribute to Serena's behavior?

3. How might the teacher misinterpret Serena's behavior?

Traumatic Brain Injury Checklist

Student:______________________________ Grade:__________ Date of Injury:______________
School:_______________________________ Current Date:___________________

Please rate the student's behavior (in comparison to same-age classmates) using the following rating scale:

Not at all
Occasionally
Often
Very Severe & Frequent Problem

Not At All	Occasionally	Often	Very Severe & Frequent Problem	
				A. Orientation and Attention to Activity
				Confused with time (day, date); place (classroom, bathroom, schedule changes); and personal information (birth date, address, phone, schedule)
				Seems "in a fog" or confused
				Stares blankly
				Appears sleepy or to fatigue easily
				Fails to finish things started
				Cannot concentrate or pay attention
				Daydreams or gets lost in thoughts
				Inattentive, easily distracted
				B. Starting, Changing, and Maintaining Activities
				Confused or requires prompts about where, how or when to begin assignment
				Does not know how to initiate or maintain conversation (walks away, etc.)

Not At All	Occasionally	Often	Very Severe & Frequent Problem	
				Confused or agitated when moving from one activity, place, or group to another
				Stops midtask (math problem, worksheets, story, or conversation)
				Unable to stop (perseverates on) inappropriate strategies, topics, or behaviors
				Gives up quickly on challenging tasks
				C. Taking in and Retaining Information
				Forgets things that happened even the same day
				Problems learning new concepts, facts, or information
				Cannot remember simple instructions or rules
				Forgets classroom materials, assignments, and deadlines
				Forgets information learned from day to day (does well on quizzes, but fails tests covering several weeks of learning)
				D. Language Comprehension and Expression
				Confused with idioms ("climbing the walls") or slang
				Unable to recall word meaning or altered meaning (homonym or homographs)
				Unable to comprehend or breakdown instructions with request
				Difficulty understanding "Wh" questions
				Difficulty understanding complex or lengthy discussion
				Processes information at a slow pace
				Difficulty finding specific words (may describe but not label)
				Stammers or slurs words
				Difficulty fluently expressing ideas (speech disjointed, stops midsentence)

Not At All	Occasionally	Often	Very Severe & Frequent Problem	
				E. Visual-Perceptual Processing
				Cannot track when reading, skips problems, or neglects a portion of a page of written material
				Orients body or materials in unusual positions when reading or writing
				Gets lost in halls and cannot follow maps or graphs
				Shows left-right confusion
				F. Visual-Motor Skills
				Difficulty copying information from board
				Difficulty with notetaking
				Difficulty with letter formation or spacing
				Slow, inefficient motor output
				Poor motor dexterity (cutting, drawing)
				G. Sequential Processing
				Difficulty with sequential steps of task (getting out materials, turning to page, starting an assignment)
				Confuses the sequence of events or other time-related concepts
				H. Problem-Solving, Reasoning, and Generalization
				Fails to consider alternatives when first attempt fails
				Does not use compensatory strategies (outlining or underlining)
				Problems understanding abstract concepts (color, emotions, math and science)
				Confusion with cause-effect relationships

Not At All	Occasionally	Often	Very Severe & Frequent Problem	
				Unable to categorize (size, species)
				Problems making inferences or drawing conclusions
				Can state facts, but cannot integrate or synthesize information
				Difficulty applying what they know in different or new situations
				I. Organization and Planning Skills
				Difficulty breaking down complex tasks (term papers, projects)
				Problems organizing materials
				Problems distinguishing between important and unimportant information
				Difficulty making plans and setting goals
				Difficulty following through with and monitoring plans
				Sets unrealistic goals
				J. Impulse or Self-Control
				Blurts out in class
				Makes unrelated statements or responses
				Acts without thinking (leaves class, throws things, sets off alarms)
				Displays dangerous behavior (runs into street, plays with fire, drives unsafely)
				Disturbs other pupils
				Makes inappropriate or offensive remarks
				Shows compulsive habits (masturbation, nail biting, tapping)
				Hyperactive, out-of-seat behavior

Not At All	Occasionally	Often	Very Severe & Frequent Problem	
				K. Social Adjustment and Awareness
				Acts immature for age
				Too dependent on adults
				Too bossy or submissive with peers
				Peculiar manners and mannerisms (stands too close, interrupts, unusually loud, poor hygiene)
				Fails to understand social humor
				Fails to correctly interpret nonverbal social cues
				Difficulty understanding the feelings and perspective of others
				Does not understand strengths, weaknesses and self presentation
				Does not know when help is required or how to get assistance
				Denies any problems or changes resulting from injury
				L. Emotional Adjustment
				Easily frustrated by tasks or if demands not immediately met
				Becomes argumentative, aggressive, or destructive with little provocation
				Cries or laughs too easily
				Feels worthless or inferior
				Withdrawn, does not get involved with others
				Becomes angry or defensive when confronted with changes resulting from injury
				Apathetic and disinterested in friends or activities
				Makes constant inappropriate sexual comments and gestures
				Unhappy or depressed affect
				Nervous, self-conscious, or anxious behavior

Not At All	Occasionally	Often	Very Severe & Frequent Problem	
				M. Sensorimotor Skills
				Identified problems with smell, taste, touch, hearing or vision
				Problems discriminating sound or hearing against background noise
				Problems with visual acuity, blurring or tracking
				Problems with tactile sensitivity (e.g., cannot type or play an instrument without watching hands)
				Identified problems with oromotor (e.g., swallowing), fine motor or gross motor skills
				Poor sense of body in space (loses balance, negotiating obstacles)
				Motor paralysis or weakness of one or both sides
				Motor rigidity (limited range of motion), spasticity (contractions) and ataxia (erratic movements) **circle one**
				Impaired dexterity (cutting, writing) or hand tremors
				Difficulty with skilled motor activities (dressing, eating)

Waaland and Bohannon (1992)

Reprinted from Guidelines for Educational Services for Students with Traumatic Brain Injury (Virginia Department of Education, 1992)

TRAUMATIC BRAIN INJURY EVALUATION PLANNING

Student:____________________________ Grade:_________ Date of Injury:_____________

School:______________________________ Current Date:__________________

This worksheet is intended to help educators

1) *identify the types of information to gather when planning an evaluation of a student with a brain injury.*
2) *be aware of the major issues they need to address before a student with a brain injury returns to school.*

I. Brain Injury Information. *Note available information about the injury.*

A. Type of injury *(e.g., internal or external cause, congenital/birth trauma, open or closed)*

B. Location of injury

C. Coma information (if applicable) *(e.g., duration, GCS score)*

D. Post-traumatic amnesia (if applicable)

II. Summary of Student Functioning Prior to Brain Injury

III. Areas of Current Functioning to Examine *Describe the student's functioning in the areas listed below. Do you have enough information to determine whether limitations exist in these areas? If not, what additional information do you need?*

A. Cognition (such as memory, attention, reasoning, abstract thinking, judgment, problem solving, information processing, executive functions)

B. Speech and Language/ Communication

C. Sensory and perceptual Abilities

D. Motor Abilities

E. Psychosocial impairments

F. Physical/health/safety (e.g., self-care abilities, medical/physical needs)

G. Academic skills

IV. What information have the parents provided?

V. What are the MAJOR issues you think you will need to address in preparing for the student's return to school?

Wisconsin Chapter 115

115.782 Evaluations. (1) The local educational agency shall do all of the following:

(a) Notify the parents of the child, in accordance with s.115.792, of any evaluation procedures the agency proposes to conduct and the names of the individuals who will conduct the evaluation if known.

(b) Except as provided in par. (c), before conducting an initial evaluation of a child, obtain informed consent from the child's parent. Parental consent for the evaluation does not constitute consent for placement for receipt of special education and related services. If the child's parents do not consent to the evaluation, the local educational agency may continue to pursue an evaluation by using the procedures under s. 115.797 or 115.80.

(c) Before conducting an initial evaluation of a child who is a ward of the state, obtain informed consent in compliance with 20 USC 1414 (a) (1) (D) (iii).

(2) CONDUCT OF EVALUATION. (a) In conducting the evaluation, the individualized education program team shall not use any single measure or assessment as the sole criterion for determining whether a child is a child with a disability or for determining an appropriate educational program for the child. The individualized education program team shall do all the following:

1. Use a variety of assessment tools and strategies to gather relevant functional, developmental, and academic information, including information provided by the child's 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.

2. Use technically sound instruments that may assess the relative contribution of cognitive and behavioral factors, in addition to physical or developmental factors.

3. Ensure all of the following:

a. That assessments and other evaluation materials used to assess a child under this section are selected and administered so as not to be racially or culturally discriminatory and are provided and administered in the language and form most likely to yield accurate information on what the child knows and can do academically, developmentally, and functionally, unless it is clearly not feasible to do so.

b. That assessments and other evaluation materials given to the child are used for the purposes for which they are valid and reliable, are administered by trained and knowledgeable personnel, and are administered in accordance with any instructions provided by the producer of the assessments or evaluation materials.

c. That the child is assessed in all areas of suspected disability.

d. That assessment tools and strategies that provide relevant information that directly assists persons in determining the educational needs of the child are used.

(b) As part of an initial evaluation of a child and as part of any reevaluation of a child under sub. (4), the individualized education program team and other qualified professionals, as determined by the local educational agency, shall do all of the following:

1. Review existing evaluation data on the child, including evaluations and information provided by the child's parents; previous interventions and the effects of those interventions; current classroom-based, local, or state assessments; classroom –based observations; and observations by teachers and related services providers.

2. On the basis of that review and information provided by the child's parents, identify the additional data, if any, that are needed to determine all of the following:

a. Whether the child has a particular category of disability and the educational needs of the child or, in case of a reevaluation of a child, whether the child continues to have such a disability and such educational needs.

b. The present levels of academic achievement and related developmental needs of the child.

c. 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.

d. Whether any additions or modifications to the special education and related services are needed to enable the child to meet the measurable, annual goals specified in the child's individualized education program and to participate, as appropriate, in the general curriculum.

(c) The local educational agency shall administer such assessments and other evaluation measures as may be needed to produce the data identified under par. (b) 2.

(f) The local educational agency shall ensure that the evaluation of a child with a disability who transfers from one school district to another in the same school year is coordinated with the child's prior and subsequent schools as necessary and as expeditiously as possible to ensure prompt completion of the evaluation.

(3) DETERMINATION OF ELIGIBILITY FOR SPECIAL EDUCATION. (a) Upon the completion of the administration of assessments and other evaluation measures, the individualized education program team shall determine whether the child is a child with a disability and the educational needs of the child. The team may not determine that a child is a child with a disability if the determinant factor for the determination is lack of appropriate instruction in reading, including in the essential components of reading instruction, as defined in 20 USC 6368 (3), or lack of instruction in math, or because the child has limited proficiency in English.

(b) The individualized education program team shall prepare an evaluation report that includes documentation of determination of eligibility for special education. The local educational agency shall give a copy of the evaluation report, including the documentation of eligibility, to the child's parents.

(4) REEVALUATIONS. (a) A local educational agency shall ensure that the individualized education program team does all of the following:

(1) Evaluates a child with a disability in accordance with this section before determining that the child is no longer a child with a disability, except that an evaluation is not required before the termination of a child's eligibility for special education and related services because he or she graduated from secondary school with a regular diploma or because h or she reached the age of 21. In those circumstances, the local educational agency shall provide the child with a summary of the child's academic achievement and functional performance, including recommendations on how to assist the child in meeting his or her postsecondary goals.

(2) Reevaluates a child with a disability in accordance with this section if the local educational agency determines that the educational or related services needs of the child, including the child's academic performance, warrant a reevaluation or if the child's parent or teacher requests a reevaluation. The individualized education program team shall reevaluate a child no more frequently than once a year unless the child's parent and the local educational agency agree otherwise and at least once every 3 years unless the child's parent and the local educational agency agree that a reevaluation is unnecessary.

(b) The local educational agency shall obtain informed consent from the child's parent before reevaluating a child with a disability, except that such consent need not be obtained if the local educational agency has taken reasonable measures to obtain such consent and the child's parents have failed to respond.

(c) If the individualized education program team and other qualified professionals, as determined by the local educational agency, find under sub. (2) (b) 2. that no additional data are needed to determine whether the child continues to be a child with a disability or to determine the child's educational needs, the local educational agency shall notify the child's parents of that finding and the reasons for it and the right of the child's parents to request an assessment to determine whether the child continues to be a child with a disability and to determine the child's educational needs. The local educational agency is not required to conduct such an assessment unless the child's parents request it.

History: 1997 a. 164; 1999 a. 117; 2005 a. 258.
Cross Reference: See also s. PI 11.35, Wis adm. Code.