IOWA PRESCHOOL HANDICAPPED

PROGRAM INFORMATION

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Department of Public Instruction
Special Education Division
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Des Moines, Iowa 50319

State of Iowa
DEPARTMENT OF PUBLIC INSTRUCTION
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Des Moines, Iowa 50319

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DEFINITIONS

Preschool handicapped are those pupils below compulsary school age who require special education instruction and/or support services which are not appropriately provided within the scope of general education or other special education instructional programs. Such instruction or service will reasonably permit the child to enter the educational process or school environment when the child attains school age.

The mandate for appropriate services for ALL handicapped children from birth to 21 years of age is a component of Chapter 281.2 of the Code of Iowa as follows:

> 281.2
>
> 1. "Children requiring special education" means persons under twenty-one years of age, including children under five years of age, who are handicapped in obtaining an education because of physical, mental, emotional, communication or learning disabilities or who are chronically disruptive, as defined by the rules of the department of public instruction.
>
> Special aids and services shall be provided to children requiring special education who are less than five years of age if the aids and services will reasonably permit the child to enter the educational process or school environment when the child attains school age.

The Iowa Rules of Special Education provide the basic structure for all programs and services for preschool handicapped students.

Public Law 94-142 mandates that a free appropriate public education be available for all handicapped children between the ages of three and eighteen within the State no later than September 1, 1978, and ages three through twenty-one by 1980. Federal funds can be used to provide

programs and services for handicapped children from birth through age two, although these children are not counted for purposes of generating revenue under P.L. 94-142.

PHILOSOPHY

Historical Perspective

Due to the developmental sequences which children follow, the early years are the most critical time to identify, ameliorate, or remediate to the greatest extent possible, a child's mental, physical, social, and emotional deficiencies. The lack of attention to a child's handicaps during the early childhood developmental period may lead to irreversible deterioration of their potential for leading a more normal useful life. Oftentimes, the goals for moderately and severely handicapped youngsters are to assist them and their families in adapting to a handicap that will always be with them, while the goals for mildly handicapped children are for total integration with normal children.

During the past decade, there has been a noticeable increase in availability of services and programs for preschool handicapped children. Such educational programs with related support services were seen as being long overdue by persons concerned with the welfare and optimum development of young children. Such projects as Head Start, First Chance Projects funded via the Bureau for Education of the Handicapped, Title I Preschools and many other agency efforts have helped to provide more equal opportunity for young handicapped and economically disadvantaged children. Parents who are better educated as to the needs and rights of

their children have also been a definite force in the development of more uniform services for children with special needs.

In recognition of a need for early intervention, the Handicapped Children's Early Education Assistance Program was authorized by the federal government to establish and operate model preschool and early education projects. Prior to the HCEEP Projects, some services for preschool handicapped were provided through such agencies as the Easter Seal Society and Association for Retarded Citizens, in addition to state institutions and private providers.

Four BEH projects were developed in Iowa and made a definite contribution to Area Education Agencies and Local Education Agencies who later established preschool programs. The four BEH funded projects were 1) Access to Success, Des Moines 2) Marshalltown Project, Marshalltown, 3) Early Childhood Program, Cedar Rapids, and 4) PERSON, Mason City. Grants made available through Developmental Disabilities were also utilized in some cases to fund programs for preschool aged handicapped. One such program which was operational for several years was located on the Eastern border of Iowa in the Scott-Muscatine area.

Components from each of these projects have remained in operation either through AEA or LEA sponsorship. The accomplishments within these programs are a definite tribute to those who provided the early leadership for their development. For example, the Marshalltown Project still provides a training program which may be utilized by home instruction teachers throughout the nation.

Due to the foresight of the Iowa state legislature and various state agencies, Iowa currently has comprehensive services to provide assistance to children in need of special education programs and services from birth to 21 years of age. By accepting the challenge of providing needed instructional and support services for young children, Iowa has become one of the leaders in the nation in moving toward provision of full service for all children with special needs.[1]

FUNDING

As Iowa had no mandatory special education programs available to the handicapped below the age of five years prior to July 1, 1975, the preschool population was deemed by the Division of Special Education, Iowa Department of Public Instruction to be the "largest unserved population" between the ages of 0 - 21. Such a designation was made, with approval by the State Board of Education, to utilize a major portion of the 94-142 (EHA-Part B) funding to provide necessary programs and services to this "unserved population".

Distribution of the funds is made to the fifteen Area Education Agencies on the basis of number of students currently receiving special education programs and services within their geographic boundaries. The 94-142 funds, although generated on the basis of number of students served, must be spent on previously unserved students. AEAs are required to submit annual project applications and year end reports to the State Education Agency. Funds may be allocated for: instructional and support

[1] "Iowa Law Review, June, 1977".

staff; paraprofessionals; parent education projects; inservice training; pupil and staff transportation; facility rental for center based classes; equipment and supplies; screening services; and medical diagnostic evaluations needed to obtain information regarding the handicapped condition of the child.

Although home instruction teachers and support personnel serving at the preschool level are typically provided via the fifteen Area Education Agencies and are funded by the 94-142 projects within each AEA; these personnel may be included in the regular budgets for special education support services provided by the AEAs.

Preschool handicapped children may also be indexed on a weighted per pupil basis for the generation of state and local funds. A nonhandicapped kindergarten aged child would be indexed at 1.0 of a school district's average per pupil cost. If the per pupil cost for a district was $2,000.00, each general education student would generate that amount of state and local dollars. Since excess costs will be incurred for children in need of special education, these children are indexed with "weighted factors" to cover such costs. Excess costs, usually result from smaller pupil-teacher ratios special materials and equipment and increased costs of transportation, etc. For example, the mild to moderately handicapped preschool student whose appropriate placement would be in a self-contained class, would be indexed at the 2.2 factor and would generate $4,400.00. In these classrooms, the pupil-teacher ratio should not exceed eight children to one teacher. The employment of an aide is strongly recommended. As young children are usually totally dependent on the adults within the

classroom, it is viewed as best practice to always include a salaried teacher's aide when staffing a center based program for preschool handicapped.

Many AEAs and LEAs have chosen to provide half-day programs for preschool aged handicapped. In some situations this enables a teacher and aide to provide services for two different groups of children within a district. A large number of factors may influence the decision as to whether programs will be operated on a half or full time basis.

When the preschool aged handicapped child is weighted (or indexed), he/she generates the 1.0 funding based on the resident districts per pupil cost and additional monies to provide for the excess cost of the special education program. A preschool handicapped child who is weighted 2.2 and placed in a part-time program will actually be generating 1.6 times the district's per pupil cost; 1.0 on the same basis as all regular pupils plus one-half of the additional 1.0 . If a student is severely handicapped and requires a teacher-pupil ratio of 1:5 and receives a half day program, that child will generate the regular 1.0 which is generated for regular pupils in that particular district and an extra 1.4 which is one half of the additional weight of the 2.8. On a half time basis, this severely handicapped student would generate a total of 2.4 times the district's per pupil cost.

From the amount generated by each handicapped public school student, the districts which provide their own program will retain 25% of the first 1.0 for items such as operation and general maintenance of classrooms, regular transportation, and administration. (The 25% factor applies to those students who are weighted 3.8; a 30% factor is applied to costs

for students who are weighted 2.2). Districts who operate preschool programs under a contractual arrangement utilizing 94-142 funds would be entitled to request administrative costs.

Area education agencies may choose to operate programs in two different ways when utilizing 94-142 funds. The area education agency may develop a contract with a local district and agree to pay total program costs of the district. Approximate costs should be estimated prior to the development of the contract. Such an arrangement would provide the local district administrative control over the preschool program and place teachers on local district contracts with no direct line supervision from AEA staff.

A second option would be to have area education agencies assume full responsibility for operation of classrooms within the local districts. Some districts are extremely hesitant to establish programs for preschool handicapped and prefer that the AEA take this responsibility.

With either option, the AEA remains the applicant agency for the federal funds and is, therefore, responsible for the tracking of all equipment purchased which has a value of $300 or more. The area education agency must maintain this responsibility for five years from time of purchase. The equipment must be used for the purpose it was intended and cannot be transferred to regular education programs.

Supplemental assistance may be necessary when a child attempts the transition from the smaller preschool handicapped class to a traditional

kindergarten setting. If the staffing team determines that an aide is needed to facilitate success for a specific child, the child could be weighted 1.7 upon kindergarten entrance.

In order to minimize delays in establishing needed centers for young newly identified handicapped, a portion of the 94-142 Preschool Incentive Grant is maintained by the SEA for the purpose of facilitating new preschool classes during a school year. If an LEA or AEA has identified several children whose appropriate placement would be a self-contained special class, the AEA my submit an application stipulating the location of the program, number of children and other requested information. If the application is approved, all start-up costs for the class would be made available. At the end of the school year for which funds were allocated, the program costs would be shifted to regular 94-142 funding, or the children "weighted" for the generation of state and local funds.

In some rural districts, programs for preschool handicapped are being funded through a procedure which includes both "weighted" and federal funds. Because of population distribution, there may be an inadequate number of handicapped preschool children to generate sufficient "weighted" funds for the provision of a class. In such cases, it is suggested that federal funds be used to supplement the state and local effort. Such expenditures are seen as excess costs with no decreased effort from the state or local level. All state and local special education funds which are generated in behalf of preschool aged children must first be expended prior to utilizing federal funds to avoid supplanting.

INTRODUCTION

PROGRAM OPTIONS

Children who are identified as handicapped and are between the ages of birth and seven years by September 15 of a given year, may be served in one, or a combination, of the available program options. Children may be entered or removed from the various options during the year dependent upon the needs of the child. A greater intensity of programs and services may be required during certain phases due to greater need by the child and family.

Any child placed in one of the Iowa special education program options must be categorized by disability area specified as a handicapping condition. Such a designation of disability may change as additional data is gathered resulting in more definitive diagnosis. In some situations early intervention may remediate a condition and a child formerly designated as handicapped may move into general education without need for continued special education services. In other cases it may be necessary to retain some children on a monitor basis for a period of time to determine if any type of special support will be needed.

Due to difficulty of correctly pinpointing the disability for some handicapped children below the age of three years, it is acceptable to place children in a "deferred diagnosis" status for a maximum time period of one year or until such time as an accurate educational diagnosis can be obtained. "Deferred diagnosis" status must be changed to a

specific disability category when the child reaches his/her third birthday prior to September 15 of that year.

Deferred diagnosis status should be utilized only when determination of a specific disability area cannot be made. For example, if a child is known to have Down's Syndrome, be visually or hearing impaired, or severely/ profoundly handicapped, the appropriate category is to be selected and coded when data is collected in December of each year. Conditions which can be determined from existing medical and/or educational diagnosis should be coded by disability on the child's records and use of the "deferred diagnosis" status should not be considered. Only a small percentage of the handicapped between the ages of birth and age three should require the utilization of the "deferred diagnosis" category as most children requiring special education programs and services at this age usually fall within the moderate to severe range of handicapping conditions. Within these ranges, the determination of disability can usually be made with greater precision.

All children receiving service while placed in the "deferred diagnosis" category must have on file an interdisciplinary staffing report which contains the observational, medical, and educational assessment information obtained prior to placing the child in the diagnostic category. (Rules of Special Education, 12.19). Detailed health histories shall be obtained on all children prior to beginning special education programs or services. Such histories are to be obtained by a nurse whenever possible. All children receiving special education programs or services who are placed in the deferred diagnosis category must have had a hearing assessment

prior to placement. If valid hearing assessment results are not attainable due to the inability to condition the child or for other reasons, continued attempts should be made until valid results are obtained.

An annual review is to be held on these children to determine: a) if additional data obtained permits a current, accurate diagnosis to be established; b) whether the child is to continue receiving programs and c) the child is no longer in need of programs and/or services.

It remains the responsibility of the professionals providing the special education programs and services to keep parents informed of the developmental status of the child as perceived by the staff, i.e., amount of developmental lag exhibited by the child in areas of motor, cognition, and language. Information regarding adaptive behavior may also be interpreted to parents. As soon as the disability area can be determined, this information is to be shared with parents and support provided to assist parents in understanding the special needs of their child.

As with any young child in need of special education programs or services, the parents are a critical member of the service team. The educational and diagnostic personnel should make every effort to explain the child's needs and stress the importance of early intervention for the child.

Whether an Area Education Agency chooses to use the "deferred diagnosis" category is optional. All children who are weighted in order to generate state and local funding must be placed in one of the appropriate

categories based on their primary disability. The "deferred diagnosis" category is only available for 0-3 children who are served with federal funds.

Program options available to the handicapped child below age three are home instruction, center based classes, and support services such as physical or occupational therapy, audiology, speech therapy, social work, and pyschological services.

All program placements recommended for a child should be based on formal assessment and observational data. The primary consideration should be the provision of the least restrictive appropriate program. With preschool aged handicapped, this could be a combination of program options in order to provide opportunities for appropriate integration with non-handicapped peers. For example, it is sometimes possible to continue a five or six year old in a half-day special education program and a half-day kindergarten program.

It is important for staff to analyze program strengths and weaknesses, as well as needs of the handicapped child in selecting the appropriate program model. Persons with special knowledge of preschool handicapped should continuously monitor the quality of available options. An ongoing analysis of children and programs should be maintained to assist with determining changes which may need to be made.

PROGRAM OPTIONS DEFINED

1. CATEGORICAL OR MULTI-DISABILITY SELF-CONTAINED SPECIAL CLASS

A. May be operated by AEA or LEA.

B. May be half day or full day in length. (20 hours or more per week constitutes a full time program.)

C. May include handicapped between ages of birth to mandatory school age.

D. Classes may accommodate a maximum of eight children per session for mild-moderate range of severity with one teacher. An aide is strongly recommended.

E. Classes may accommodate a maximum of five children per session for severely or severely/profoundly handicapped with one teacher and one aide.

F. A minimum staff ratio of one certified teacher with a minimum of one aide per classroom recommended.

G. May be established with two time options:

1. 5-0 (5 days/week - children in attendance center)

2. 4-1 (4 days/week - child in attendance center with 1 day/week being utilized by teacher for home visitation and/or group parent education)

H. Students in special classes are weighted at 2.2 or 3.8. Specific documentation and a rule exception are required where classes contain children with different weighted factors.

I. Should be coupled with a strong emphasis on parent instruction and inservice in order to maximize instructional carry-over into the home.

2. HOME INSTRUCTION:

A. An instructional program which is provided in the home and is accompanied by educational and developmental assessment which is translated into prescriptive plans based on individual goals and objectives for the child.

B. Focuses on modeling and sharing teaching techniques with parents and employs necessary follow-up to assist in updating child's program. The visitation schedule should be based on the needs of the child and the capabilities of the parent to follow through with the prescriptive plans developed by the teacher with input from the parents.

C. Provides an early intervention program for those children who could not appropriately be served in a center-based program.

D. Play materials and equipment may be maintained by the AEA or LEA for loan purposes for children requiring specialized materials and equipment. Books and materials which would be resources to the parents of handicapped children may also be made available for check-out.

E. May be supplemented with support services such as those which could be provided by a speech clinician, psychologist, physical or occupational therapist, social worker, special education nurse or other AEA support personnel.

F. Caseloads would typically consist of not more than twelve to fifteen families per teacher. To be considered as part of the caseload, a family would be scheduled for a minimum of two visits per month. A family could receive as many as two to three visits per week, dependent on child and/or family needs. A child placed on monitor would not be viewed as part of the teacher's regular caseload. Families within a caseload may vary during the school year due to identification of additional children, changes in needs of specific children, family mobility, etc.

G. Caseloads will vary in size due to numerous variables, i.e. geographic area being served (travel time being a major consideration) intensity of services needed by the child and family; other duties also performed by the home instruction teacher; additional support personnel supplying services; capabilities

of the teacher; and administrative philosophy. Time must be alloted for planning, staffings, agency contacts and other coordination activities to be carried out by the teacher.

3. PROGRAMS FOR INTEGRATION

A. "Shall meet criteria as specified in the rules of special education. 12.19 (8) Placement of a preschool handicapped pupil in a licensed preschool program for nonhandicapped pupils may be made provided that":

a. The child is also enrolled in a home instruction or center-based program in addition to placement in a preschool for nonhandicapped children.

b. The pupil's special education needs are of a unique nature and cannot be met in other special programs for preschool handicapped pupils.

c. Appropriate special education support services are provided in accord with the pupil's needs.

d. The length of any single placement is for one academic year or less.

e. The director of special education has approved the individualized educational plan and a procedure for ongoing evaluation.

f. The preschool teacher serving the handicapped child is appropriately certified by the Division of Teacher Education and Certification. (Teacher to hold preschool - kindergarten certification - Endorsement #53).

g. An appropriate special education consultant from the Area Education Agency is assigned to each pupil to regularly monitor through twice a month site visits, the child's progress and performance.

B. May be requested to submit progress reports to the LEA or AEA responsible for providing an appropriate educational program for the identified child.

C. May have tuition and transportation costs provided from 94-142 allocations if requests for this purpose are included in the annual 94-142 application.

D. May be provided by Head Start programs. Close working relationships exist between the Head Start classes and other programs for preschool handicapped as such cooperation enhances the ability of all involved to provide the most appropriate programs and services possible for preschool handicapped children.

4. SUPPORT SERVICE ONLY

A. Children needing only support services may receive those services in a designated center on a regular basis or the support personnel may provide therapy or consultation in the home.

B. Every effort should be made to assist the parents in working most effectively with the child rather than having the family build a dependency on the support or instructional personnel.

Aides and Volunteers

A "teacher aide" or "teacher associate" is identified as a person employed full or part time to assist with programming and other necessary duties within the classroom. Due to their critical role within the preschool classroom, substitutes for the aide should be employed in his/her absence. It is viewed as a dangerous and exhausting situation for the teacher to function in a classroom with young handicapped children without a second adult present.

Volunteers who are capable of assisting in the classroom are an often untapped resource within classes for young handicapped children. Many parents are willing to volunteer their time on a regular basis and can contribute substantially, in addition to, acquiring knowledge about how their child functions within the school environment as compared to the home environment. Oftentimes teachers will choose to have the parents work with other children within the class rather than their own child.

In some communities, high school and college students are available as volunteers. It is necessary for teachers to understand how to best utilize other adults within their classroom in order to maximize individualized instruction for young children. Unless volunteers can feel they are providing a vital service within the classroom, they seldom remain enthusiastic and will discontinue their involvement in the program.

GENERAL INFORMATION

In all types of program options it is critical to constantly reevaluate the needs of the child and the family. Services and programs should be continued only as long as necessary. It is sometimes difficult for parents and those in educational services to adjust themselves to moving children in or out of a program during a school year as this is the traditional framework utilized for school aged children. Appropriate services and programs can be provided for preschool handicapped only by realizing that services must be intensified at certain periods to best meet either child or family needs, while in other periods, the child or family may require only intermittent follow-up.

The AEA supervisor or consultant of preschool handicapped plays an important role in establishing a systematic review process with persons supplying direct service to children. Teachers or support persons may become particularly close to a specific family or child and may be maintaining services which meet their own needs rather than that of the family and child. A supervisor or consultant is sometimes in a better position to objectively review a situation and assist with decisions regarding intensifying or decreasing programs or services.

STAFFING

Multidisciplinary staffings are to be conducted on each child prior to placement in special education programs. The staffing is a process for the review of information regarding the current developmental functioning level of a child in order to formulate, implement, and evaluate programs or services. The formal assessment and observation information is to be

provided through an inter-disciplinary approach which may include medical, instructional and support service input. The staffing committee should be composed of persons familiar with the needs of the child who can provide information or expertise in developing the most appropriate educational plan for the student. The staffing committee may include: 1) Teachers who are currently involved in programming for the child; 2) Parents of the child; 3) Medical or support personnel who have been involved in the diagnostic evaluations; 4) Principal from the district of residence of the child; as well as principal of the receiving district; 5) Director of Special Education or his/her designated representative; 6) Appropriate Persons from other agencies which have been involved with the child and/or family; 7) Preschool teachers who may have referred, or be likely to receive, the child into a program. (Included here could be Head Start, Title I preschool teachers, etc.)

One member of the full staffing team should serve as chairperson. Because of his/her overall responsibility for the educational program of the building, it is suggested that the principal assume this responsibility. In some situations, an AEA designated representative will coordinate the staffing.

The chairperson's responsibility is to see that the staffings are carried out in a professional manner and that written documentation of the proceedings are maintained. The staffing chairperson may also accept responsibility for follow-up to insure the recommendations of the staffing committee are being implemented and that each staff member is meeting commitments to the student. The Area Education Agency Director of Special Education, through the appropriate program specialist, is

ultimately responsible for ascertaining that each handicapped student is receiving the most appropriate overall educational program.

It is crucial that parents of preschool aged children attend staffings at all times. Since the staffing process may be especially intimidating to young parents, it is suggested that a home-school liaison be responsible for contacting parents personally if the parents do not respond to written notification. Every effort to have the parents present at the staffing should be documented. In order for the intervention to have optimum benefits for the child, it is essential for parents to understand the reason for the prescribed intervention strategies. As parents have oftentimes learned a great deal about capabilities and limitations of their child, it can prove highly beneficial to have parental input at the staffing. A concerted effort should be made to prevent the parent from becoming only a passive observer during the staffing process.

Careful documentation should be made of the proceedings during the staffing, i.e., the staffing report should ultimately yield a written summary of the available diagnostic information, persons in attendance at the staffing, program and services needed by the child, available program options, timelines for implementation and review of appropriate program. Information should also be synthesized on specific student behaviors or capabilities which appear to have a positive or negative effect on functioning level of the student. Responsibilities should then be assigned, e.g., what agency is held responsible for service, what are the responsibilities of the parents, and who is to be responsible for the transfer of records. Each child's program is to be reviewed at least annually, however, with preschool aged children it may be necessary

to hold follow-up staffings more frequently due to their more rapid change in developmental status.

Staffings may be seen functionally as grouped into three types:

Type 1) Identification and selection of intervention model.

A Type I staffing should include: 1) Source of referral. 2) Pertinent information regarding screenings, assessment, and diagnostic evaluation. 3) Parental observational input. 4) The review of the child's known strengths and deficits at the present time. 5) A determination of the need for special education program or services. 6) Recommendations for appropriate intervention model or combination of models. 7) Provisions for follow-up staffings to evaluate the efficacy of the student's program.

Type II) Prescribing the individualized educational program (IEP)

The Type II staffing is to finalize the individualized educational program which is to be developed on the basis of current assessment and diagnostic information available regarding the child. This program plan is to contain the records of the services and programs needed by the child for ultimate educational gains. Each individualized educational program will contain long-range goals, short-term objectives, and evaluative criteria for measuring progress toward meeting the objectives.

Type I and II staffings may be combined if the appropriate persons are present to successfully complete all phases.

Type III) Evaluation or follow-up

The Type III staffing is the follow-up staffing and will not necessarily be composed of all members of the original staffing team. The chairperson of the original staffing would be responsible for contacting the necessary personnel, dependent upon the reason for the follow-up staffing.

Follow-up staffings are appropriate when:

1) the original suggested programming has been implemented and does not seem to be appropriate.

2) the original goals as outlined by the full staffing committee have been satisfied.

3) the child's needs have changed and another type of educational service should be considered.

4) as part of routine program evaluation (i.e., annual review)

HEALTH HISTORY

Health and developmental history is a component of the assessment of handicapped children before provision of special education programs and services. The health and developmental history must be a part of the evaluation data necessary to determine placement. Rules of Special Education 12.19 (1)b.

Health and developmental history must be done by a registered nurse (R.N.). This may be a school nurse, special education nurse, public health nurse, or visiting nurse. If such personnel are not available for completing health and developmental histories, a data sheet is to be completed which supplies information regarding developmental milestones, known medical information and pertinent family information. Such data is frequently gathered by a social worker or home instruction teacher. When no professional nurse (R.N.) services are available, the family physician must be contacted regarding any health related questions.

IMMUNIZATIONS

Immunizations required by the Code of Iowa (Chapter 139) for school entry are applicable to <u>all</u> children receiving special education programs and services.

Immunizations for diphtheria, tetanus (lock jaw) pertussis (whooping cough) (D.T.P.) and Trivalent oral polio vaccine should be started at

two months of age. The above vaccines each require three doses to be given at least one month apart. However, an injection of combined D.T.P. and one dose of Trivalent oral polio vaccine can be administered at fifteen months of age. Mumps vaccine may be administered with the measles and rubella in a combined vaccine in one injection. At present mumps vaccine is not required although highly recommended.

Boosters for these vaccines are required periodically.

Most children should be immunized even though they may be educationally handicapped. When there is any doubt about giving any of the required immunizations to an individual child, a physician's opinion is required. The physician may give a medical exemption for all immunization or specific immunizations for the child. The length of the exemption may be for the child's school years due to a chronic (long lasting) condition or the exemption may be for specific number of weeks or months when the medical counter indication will have been eliminated.

The parents of the child may file a religious exemption.

The immunizations required in the Iowa Code are:

Age 0-2 months of age: none

2-18 months: Child should have at least one dose of combined diphtheria, tetanus and pertussis vaccine and at least one dose of trivalent oral polio vaccine (T.O.P.V.) administered.

18 months-4 years of age: The child should have had at least three doses of combined D.T.P. and at least three doses of T.O.P.V. administered. At least one dose of measles vaccine and at least one dose of rubella vaccine should be administered after 15 months of age.

4 years and older: The child must have had at least three doses of combined D.T.P. vaccine, at least one of these doses shall have been administered after the child's fourth birthday. If the child has received three doses of D.T.P. before age four, a fourth (booster) dose must be administered after the child's fourth birthday.

At least three doses of T.O.P.V. shall have been administered, one of these doses after the child's fourth birthday. If the child received the three doses before age four, a fourth (booster) dose must be administered after the child's fourth birthday.

At least one dose of rubella and at least one dose of measles vaccine must be administered after the child was fifteen months of age.

IMMUNIZATIONS REQUIREMENTS

	0 - 2 Months	2 - 18 Months	18 Months 4 Years	4 Years & Older School
DPT - TD or DT	None	At least one dose	At least three doses	At least three doses, one or more of which is after 4th birthday.
Polio (Sabin Trivalent Oral)	None	At least one dose	At least three doses	At least three doses, one or more of which is after 4th birthday.
Measles	None	None required	One dose after 12 months of age if given after January 1, 1977)	One dose after 12 months of age (15 months of age if given after January 1, 1977)
Rubella	None	None required	One dose after 12 months of age if given after January 1, 1977)	One dose after 12 months of age (15 months of age if given after January 1, 1977)
Mumps	None	Not required by law. Recommended for children 15 months of age and older except post-pubertal females.		

Special Education Nurses employed by some Area Education Agencies are a resource to AEA personnel providing programs for preschool handicapped. Some special education nurses have been assigned to a specific building population. Other special education nurses have geographic area assignments and will be more easily available to work with a variety of personnel in these areas.

Public Health Nurses. These nurses are employed by health departments to provide services to the total population with their geographic areas. It is becoming more common practice for obstetrical departments of hospitals to refer mothers with newborn babies to public health nursing service for continuing health supervision. These nurses are a valuable resource for health-related consultation with the pre-school staff. Public health nurses know the health and medical resources available within communities and areas. These nurses frequently operate child health clinics.

Visiting Nurses Association. These are usually non-tax supported agencies which provide bedside care in the home and are found in larger towns and cities. Some of these visiting nurses associations provide health clinics for low income families, and often get hospital referrals for health supervision of mothers and newborn babies.

Nurse Practitioners. These nurses have had special training in assessing growth and development, identifying health problems requiring medical intervention and have more indepth knowledge of family nurturing and child care. These may be family nurse practitioners who have emphasized child care or

school nurse practitioners who have specialized in the school age child. Family nurse practitioners and pediatrics nurse practitioners are often employed in public health agencies.

Emergency Procedures. Every center where children gather should have written emergency procedures approved by medical practitioners and the school administration, for children and employees in the center.

Rules of Special Education must be followed in relation to every medication dispensed in school.

Emergency telephone numbers for contacting persons, data on child's physician and the hospital of parent's choice where child may be taken directly.

Emergency medical service (EMS) numbers should be readily available directly.

Arrangements must be made for another responsible adult to stay with children on a moment's notice should it be necessary to the teacher to accompany the child to emergency care.

EMERGENCY PROCEDURES

Practice fire drills should be done frequently so children are aware of where they are to go. Classroom rosters should be taken so every pupil is accounted for and out of the building. For those children with mobility handicaps, arrangements must be made to evacuate them rapidly and with safety.

Tornado practice should also be simulated with the frequency necessary to give the children a familiarity with the procedure. Since this may mean staying in a dark windowless room, time should be spent there as a group to ease their anxiety.