

7-2001

Blanket Medical Excuses From Physical Education

Lauren J. Lieberman

The College at Brockport, llieberm@brockport.edu

Luz Cruz

Follow this and additional works at: http://digitalcommons.brockport.edu/pes_facpub



Part of the [Kinesiology Commons](#)

Repository Citation

Lieberman, Lauren J. and Cruz, Luz, "Blanket Medical Excuses From Physical Education" (2001). *Kinesiology, Sport Studies and Physical Education Faculty Publications*. 51.

http://digitalcommons.brockport.edu/pes_facpub/51

This Article is brought to you for free and open access by the Kinesiology, Sport Studies and Physical Education at Digital Commons @Brockport. It has been accepted for inclusion in Kinesiology, Sport Studies and Physical Education Faculty Publications by an authorized administrator of Digital Commons @Brockport. For more information, please contact kmyers@brockport.edu.

Blanket Medical Excuses From Physical Education

Possible Solutions

by Lauren J. Lieberman and Luz Cruz

Sarah is a bright, sweet 2nd grader who really loves to be active and play with her friends. Sarah also was born with spina bifida, which resulted in her being paralyzed from the waist down. She uses her wheelchair to get around school and home although she needs help to get up some steep ramps and to go long distances. She also has a shunt that prevents fluid build-up in her brain.

Sarah had an individualized education plan with specific goals to increase independence and upper body strength. These goals were written by her physical therapist the year before. The new physical therapist, Ms. Crane, became very concerned that Sarah could only push her chair for just a short amount of time. In fact, her upper body strength was extremely weak even though her level of injury from the spina bifida was at the 12th thoracic vertebrae (T-12; this means that she should have total function of her upper body and trunk). Ms. Crane contacted the parents and inquired about her previous programming. Apparently, the physician told the physical educator, Mr. Sullivan, that Sarah could not participate in physical education at all due to her shunt. Consequently, Sarah did not have physical education for the first three years of her schooling! Ms. Crane was frustrated because Sarah was a very enthusiastic and energetic girl who would really like and benefit from physical education. There was no reason she could not have been included into general physical education with modifications. Apparently, Sarah's physician was not made aware of the safe and developmentally appropriate physical education program offered by Mr. Sullivan, and Mr. Sullivan assumed that the physician knew what was best

for Sarah. The end result was that Sarah had been deprived of a critical component of her education.

Legal Rights for Physical Education

Unbeknownst to Sarah's physician or Mr. Sullivan, Sarah's exclusion from physical education violated the Individuals with Disabilities Education Act (IDEA, public law 105-17, 1997). This federal law, which was first authorized in back in the mid-1970s as the Education for All Handicapped Children Act, stated that "physical education services, specifically designed as necessary, must be made available to every handicapped child receiving a free appropriate public education" (Department of Health, Education & Welfare, 1977, p. 42489). Unfortunately, many parents, physicians, educators, and administrators do not realize the importance of physical education for children with disabilities nor the legal requirement for physical education. As a result, many children like Sarah are often given medical waivers by physicians or are excused from a local school district's physical education requirement by an administrator or physical education teacher. Lawmakers feared this when they wrote the following statement in 1977 when IDEA (at that time the law was known as the Education for All Handicapped Children Act) was first being implemented:

Special education as set forth in the Committee bill includes instruction in physical education, which is provided as a matter of course to all non-handicapped children enrolled in public elementary and secondary schools. The Committee is concerned that although these services are available to and required of all children in our school systems, they are often viewed as a luxury for handicapped children. . . . The Committee . . . specifically included physical education in the definition of special education to make clear

that the Committee expects such services, specially designed where necessary, to be provided as an integral part of the education program of every handicapped child. (Department of Health, Education & Welfare, p. 42489).

Research supports that while participation in physical activity is important for all children, it is critical for children with disabilities. Students with disabilities have less opportunity to participate in community and recreation sports (Datillo, 1991; Schleien, Ray, & Green, 1997), although many have physical conditions for which regular physical activity is important to help improve mobility and health. For example, children with cerebral palsy are prone to joint contractures if they do not participate in regular stretching activities, and children with Down syndrome are prone to obesity if they do not get regular physical activity (Wirnick, 2000). Children with cerebral palsy, muscular dystrophy, and visual impairments tend to have very sedentary lifestyles (Longmuir & Bar Or, 2000).

Current Problem

Although IDEA specifically mandates physical education for all children with disabilities, occasionally some children with disabilities receive blanket, long term medical excuses out of physical education. In many of these cases, the children's physical or medical problems can be safely accommodated in general or adapted physical education. However, physicians do not believe or have not been made aware that children with disabilities can safely participate in any form of physical education. Physicians simply may not understand the current nature of physical education (it is more than just dodgeball and regulation games), and they may not realize the support and modifications that can be provided to enable children to participate safely

and successfully in physical education.

Unfortunately, due to the initial physician's recommendations, the parents and physical education teachers will often fear involvement in general physical education classes. Parents will fear the worst due to the recommendation from the well-meaning physician and concur with exclusion from physical education. They believe they are doing what is best for their child and are often not aware of any alternatives such as adaptations, partial participation, or small group work. Physical education teachers should never defy a physician's orders. Therefore, even though they may disagree with a physician's orders, physical educators are left with no recourse other than allowing the student to sit and watch, keep score, or even go to a study hall.

Full exclusion from physical education has detrimental lifelong effects on children. Sitting out of physical education decreases physical

activity levels, decreases the development of potential motor skills, decreases time spent socializing with peers, decreases self esteem, limits number of choices for future activity due to limited opportunity, and decreases overall quality of life (Block, 2000; Sherrill, 1998).

Possible Solution

While physicians often take on a god-like quality when it comes to making medical decisions, parents and educators must realize that most physicians simply do not know what modern-day physical education entails. As noted earlier, physicians may picture physical education as 11 vs. 11 soccer games, 5 vs. 5 basketball games, or mass dodgeball games. Most physical education programs are much more developmentally appropriate and individualized. In addition, physicians may not realize the numerous types of modifications that can be made to

make physical education safe, such as lighter, softer equipment, smaller groups, modified rules, and the availability of teacher assistants and even nurses. Finally, most physicians do not realize the spectrum of physical education settings that are available in most school districts ranging from inclusive general physical education to small adapted groups to one-on-one instruction.

Physical educators, parents, and even children themselves need to take a more proactive approach in order to educate physicians who want to excuse students with disabilities from physical education. The key is to explain to physicians that children with disabilities should and can be involved in an ongoing quality physical education program that is safe, beneficial, and that meets the children's unique needs. The key to providing this program rests on open lines of communication between the general and/or adapted physical education teacher, special education teacher, parents, and physician.

When a physical educator is faced with a blanket medical excuse, there are three major steps to safely including the child:

1. Become familiar with the disability to determine possible modifications.
2. Communicate these modifications to the physician to procure permission for participation.
3. Implement the modified program and reevaluate.

STEP 1: Become Familiar With the Disability

There are many different types of disabilities that involve many complications and contraindications. It is impossible for anyone to know all of the important characteristics of each one. In order for the instructor to learn about their students' specific needs, it is important to confer with other members of their IEP team (e.g. parents, special education teacher, the physical therapist or the school nurse, and the student) as well as resources on the internet or in books. Via this information, it is possible to explain to the parents and physician the types of things that can be worked on (e.g., fitness, improved gait, development of leisure skills), the type of program (general or adapted), and the types of modifications that will be made to

TABLE 1—Common Contraindicating Conditions Leading to Exclusion and Modifications

| Contraindication | Action to Avoid | Modification |
|----------------------------|--|---|
| Atlantoaxial instability | Forward rolls (jerking of the neck), diving, heading a soccer ball, neck rolls | Log rolls, jumping in the pool, catching the soccer ball or using a nerf ball, forward head stretches |
| Asthma | Extrinsic factors (pollen, dust grass), skipping a warm-up, skipping necessary medication | Avoid extrinsic factors, use warm-up at all times, utilize prescribed medication, take breaks when necessary |
| Cystic Fibrosis | No mucus excretion plan, sustained activity with no breaks, no medication | Utilize mucus excretion plan, take breaks in physical activity when necessary, utilize prescribed medication |
| Osteogenesis Imperfecta | Pounding and jumping, contact sports, undue stress on joints | Walk and low impact activities, non-contact positions in games (peer tutor), light balls and racquets |
| Retinal detachment | Contact sports, hard balls, head jerking activities such as tumbling, heading a soccer ball, or diving | Non-contact positions in games (peer tutor), softer balls (nerf & beach balls), activities which do not jerk head such as log roll, catching ball with hands, and jumping in the pool |
| Seizures | Heights without support, swimming under water without support | Ensure spotting or harness when rock climbing, climbing ropes, or high beam, ensure a 1:1 qualified observer in the pool. |
| Shunt | Head jerking activities such as tumbling, heading a soccer ball, or diving | Activities that do not jerk head such as log roll, catching ball with hands, and jumping in the pool |
| Visual Impairment (severe) | Running alone, using a hard ball with no auditory devices | Use peer tutor when running and in games, and use ball with bells or beeper |
| Other | Look at contraindicated activity for that disability | Create alternative safe activity with the same objective as the class or IEP |

ensure safety (see Table 1 for sample modifications).

Another source of information is the list of children with allergies, health problems, medications, and contraindications that is created at most schools. Although confidential, this list is often provided to the physical education staff at the beginning of the school year. Unfortunately, this list often provides just a name and a problem. However, the physical educator, nurse, and physician can be proactive and add a third column, which would be a potential modification list. This column would state any necessary modification to ensure appropriate physical activity (see Table 2).

STEP 2: Communicate Directly With the Physician

Most physical educators and physicians are busy people, and it is often difficult to contact the physician and even more difficult to get a timely response. However, it is important that the physician be apprised of the physical educator's familiarity with the child's condition and the suggested modifications. Figure 1 gives an example of a one-page form that can be presented to the child's physician by the parents. Approval of the suggested modifications is tantamount to the inclusion of the child into physical education. The following are some suggestions to get this approval form filled out and signed by the physician.

Empower the parent to act as advocate. Because parents are seen as consumers, it will often behoove the physical educator to empower the parent to bring the form and discuss proposed adaptations with the physician. The physical education teacher must meet with the parent and educate the parent about all the options for each physical education unit discussed. The parent can then contact or meet with the physician to discuss all the options. After this initial contact by the parent it may be easier for the physical educator to communicate with the physician directly (e.g. via e-mail, fax, phone, or in person).

Physical educator meets with the school nurse. The school nurse is often more accessible and very willing to meet and discuss possible modifications for physical education. The parent can be part of this meeting, and, when all

TABLE 2—List of Students With Medical Issues With Modification

| Student Name* | Medical Issue | Modification |
|---------------------|--|---|
| Marcus Anderson | Atlantoaxial instability | Log rolls, jumping in the pool, catching the soccer ball or using a nerf ball, forward head stretches |
| Jennifer Chandler | Asthma (pollen, dust, grass, mold) | Avoid extrinsic factors, use warm-up at all times, utilize prescribed medication, take breaks when necessary |
| Gary Clinton | Ritalin | |
| Sarah Evans | Severe Asthma (stress, pollen animals) | Avoid extrinsic factors, stress relaxation, use warm-up at all times, utilize prescribed medication, take breaks when necessary |
| Valerie Kingsly | Retinal detachment | Non-contact positions in games (peer tutor), softer balls (nerf & beach balls), activities which do not jerk head such as log roll, catching ball with hands, and jumping in the pool |
| Eric Musso | Shunt | Activities which do not jerk head such as log roll, catching ball with hands, and jumping in the pool |
| Susan Oreint | Allergies (Nuts, peanut butter) | Avoid allergen |
| Jonathan Rutherford | Profoundly Deaf | Use signs, utilize interpreter, use visual cues, face him when speaking |
| Michelle Timms | Seizures (Grand mal) | Avoid heights, avoid being underwater for lengths of time, utilize peer tutor |

*All names are fictitious

three parties agree, the permission of the physician and implementation can be expedited. After the initial meeting with the school nurse, the contact with the physician for consent can be made by the nurse. The advantage of contact through the nurse is that often he/she will already have a positive professional working relationship with the physician.

Physical educator sets up meeting with physician. To facilitate communication and after obtaining permission from the child's parents, the physical educator can set up a direct meeting with the physician in person, by e-mail, or by phone contact. This way the physical education teacher can directly explain the various units in the curriculum as well as the various adaptations planned to ensure safe participation. The physical educator is likely to gain some good insight into the child's disability and medical condition, and in turn, the physical educator will be able to educate the physician about physical education and possible modifications and adaptations. While time is costly at first, if the educator were to make the time to meet with specific physicians, then a lot of time would be saved explaining and correcting later. After

this initial contact, it may be easier to send faxes or e-mails back and forth.

STEP 3: Implement the Program

Once approval has been obtained, the instructor can feel comfortable implementing the program. It is imperative that the only activities approved by the physician are implemented. Also, professional courtesy would dictate that the physical education teachers share early results of the child's success in physical education with the physician. This can be in the form of a simple note or e-mail. If there is a teacher's assistant or nurse who works specifically with the disabled child, the instructor must provide appropriate and continuous training in the modifications to this individual to make sure he/she is implementing the program as prescribed. Finally, the physical educator should conduct ongoing assessment of the program to ascertain the comfort level and success of the child, that contraindications are avoided, and that the child is meeting the intended objectives of the unit and or individualized education plan. This ongoing assessment can then be shared with the child's physician and parents in the form of a quarterly progress report.

Form Letter to Physician

To: _____ Phone: _____
 From: _____ Phone: _____

Dear _____,

At this time _____ is excluded from physical education due to _____. Full exclusion from physical education has detrimental life long effects on children. Sitting out of physical education decreases physical activity levels, decreases skill levels, decreases time spent socializing with peers, decreases self esteem, limits number of choices for future activity, and decreases overall quality of life. We understand the condition of _____ is not optimal for full participation, but we are hoping you would agree that he/she can participate with some modifications.

Please consider the following adaptations to facilitate inclusion of _____ into physical education.

Unit _____ Equipment _____

Dates of unit _____ Time of day _____

Fitness warm-up _____

Lead-up activities _____

Focus of Lesson _____

Closure activity _____

Proposed modifications to unit include: _____

| Equipment | Rules | Environment | Instruction |
|-----------|-------|-------------|-------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Other:

Please indicate appropriate adaptations to create a safe environment for _____.

If you have any questions please contact me at _____.

Or fax it back to _____ with your modifications and signature.

Thank you very much for your continued involvement with _____.

Signature

Physical Educator

Parent/guardian signature

Child signature

Figure 1—Form letter

Summary

Physical education should be an important component of every disabled child's individual educational program. Physical education is not

only required by law, but properly planned and implemented physical education can have many physical, affective, and cognitive benefits to the child. Therefore, physical educators must aggressively advocate for

physical education services for all children with disabilities. More importantly, physical educators should be prepared to deal with well-intentioned physicians who give blanket medical excuses to children with disabilities. Too often children with even relatively mild disabilities are being unnecessarily excluded from physical education because physicians perceive that physical education is not safe. This practice can have detrimental life-long effects on children with disabilities who have limited motor, fitness, and leisure skills and who already are prone to sedentary lifestyles. The three-step approach provided should give the instructor a way to combat unnecessary exclusion in physical education. With some creativity, advocacy, and communication, all children with disabilities can receive appropriate, safe, and meaningful physical education. The time and effort involved is worth the long lasting outcome.

References

Block, M.E. (2000). *Including students with disabilities in general physical education* (2nd ed.). Baltimore, MD: Paul H. Brookes.

Center for Disease Control (CDC). (1997, March). *Guidelines for school and community programs promoting lifelong physical activity*. Atlanta, GA: author.

Datillo, J. (1991). Recreation and leisure: A review of the literature and recommendations for future directions. In L.H. Meyer, C.A. Peck, & L. Brown (Eds.), *Critical issues in the lives of people with severe disabilities* (pp. 171-194). Baltimore, MD: Paul H. Brookes.

Department of Health, Education and Welfare. (1977). Nondiscrimination on basis of handicap. *Federal Register*, 42(86).

Graham, G., Holt/Hale, S., & Parker, M. (1998). *Children moving: A reflective approach to teaching physical education* (4th ed.). Mountain View, CA: Mayfield.

Individuals with Disabilities Education Act (IDEA) Amendments of 1997, PL 105-17, 20 U.S.C. 1400 *et seq.*

Longmuir, P.E., & Bar Or, O. (2000). Factors influencing the physical activity levels of youth with physical and sensory disabilities. *Adapted Physical Activity Quarterly*, 17, 40-53.

Schleien, S.J., Ray, M.T., & Green, F.P. (1997). *Community recreation and people with disabilities* (2nd ed.). Baltimore, MD: Paul H. Brookes.

Sherrill, C. (1998). *Adapted physical activity recreation and sport: Crossdisciplinary and lifespan*. (5th ed.). Madison, WI: WCB McGraw Hill.

Surgeon General. (1996). *Physical activity and health*. Washington, DC: U.S. Department of Health and Human Services.

Winnick, J.P. (Ed.). (2000). *Adapted physical education and sport* (2nd ed.). Champaign, IL: Human Kinetics. **GAPE**