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AUTHOR Stowell, I. James, Ed.; And Others
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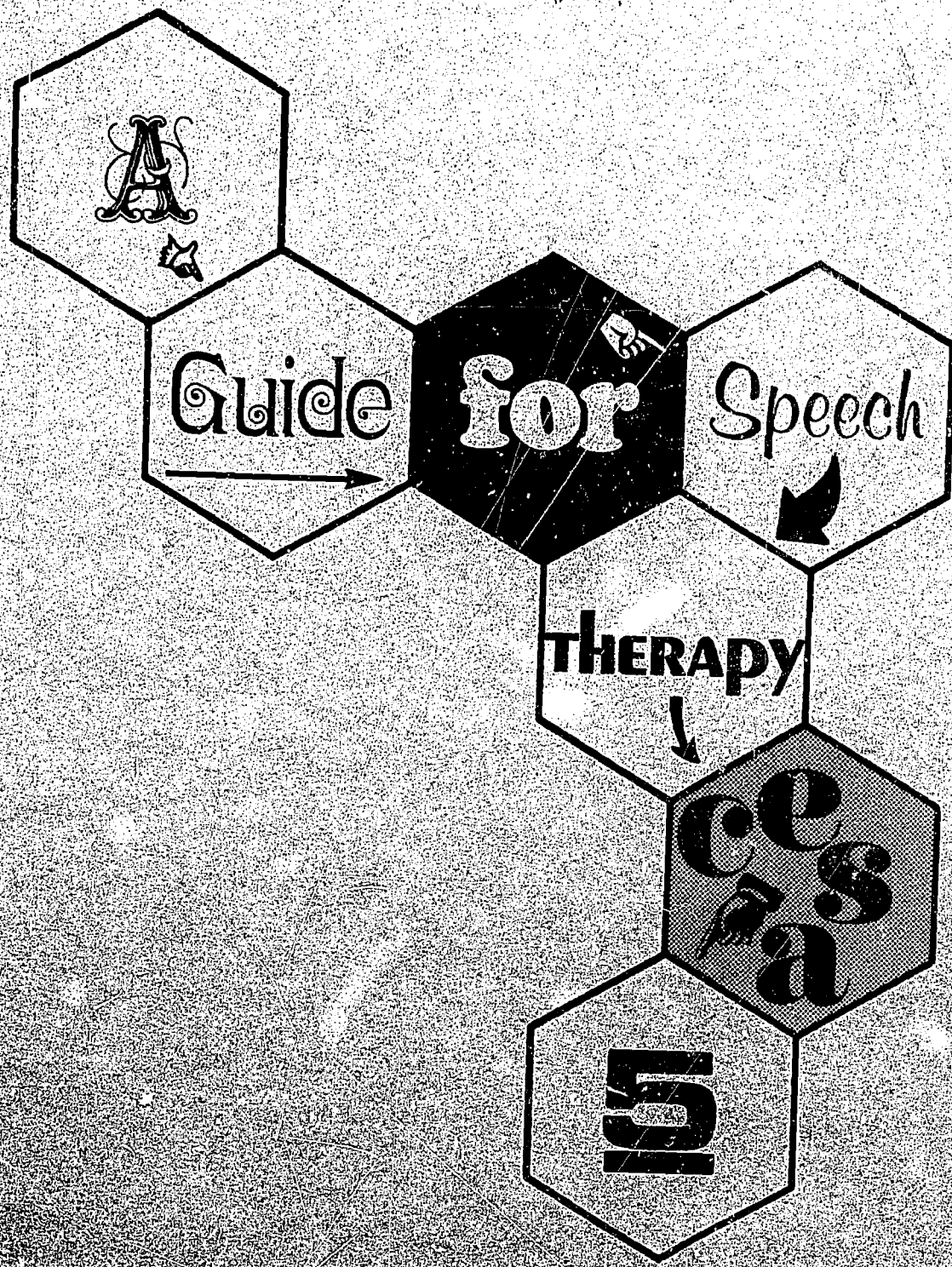
ABSTRACT

The handbook is designed as a guide to the school speech therapy programs within the Cooperative Educational Service Agency 5 in Wisconsin. A general philosophy of speech therapy is presented, the professional responsibilities of the speech clinician outlined, and professional associations described. The responsibilities of the administration to the speech therapy program, and of the classroom teacher to the speech clinician and the program, are set forth. The organization of the program is sketched, and the communication disorders found in the schools discussed. Samples of forms used by the clinicians are included. Listed are the necessary facilities and equipment for an adequate program, in addition to diagnostic and language tests, and publishing companies which are sources for diagnostic materials, therapy, and equipment. (KW)



COOPERATIVE EDUCATIONAL SERVICES AGENCY FIVE

A Guide for Speech Therapy

This handbook is a cooperative effort of the following Speech Clinicians:

L. James Stowell-Co-Editor

Sandra Heikkila-Co-Editor

Judith Gage

Ann Jacobsen

Susan Reese

Gary Siebold

Peter Tingblad

Carol VanDyke

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Cooperative Educational Service Agency 5 - Elmwood, Wisconsin 54740

William L. Terrill, Coordinator

PREFACE

The school systems in our Cooperative Educational Service Agency #5 place a high priority upon the needs of its children with special problems. One of the greatest needs is in the area of communication disorders. An all out effort is being made to remedy this situation.

The speech correction program has been accelerated the past few years, thus providing valuable services to help students with speech handicaps.

Hopefully, this handbook will provide a guide to the Speech Clinicians in Cooperative Educational Service Agency #5 and will be a useful tool to aid teachers and administrators in developing a better understanding of Speech Therapy.

George Heinemann
Director of Special Education
Cooperative Educational Service Agency
No. 5

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INTRODUCTION

Since the passing of legislation for the formation of the nineteen Cooperative Educational Service Agencies in the State of Wisconsin, the local school districts of C.E.S.A. #5 have engaged in many and varied cooperative ventures. The one of primary interest to the writers of this handbook is the speech therapy program. This handbook represents the attempt of eight speech clinicians with varied experiential and educational backgrounds to cooperate in the establishment of guidelines for the school speech therapy programs within C.E.S.A. #5.

The purposes of this handbook are several in number. They are:

1. To establish guidelines and uniformity (without depriving individual initiative) for the speech clinicians of C.E.S.A. #5.
2. To develop a general and basic philosophy.
3. To communicate to the school administrators their role in the speech therapy program.
4. To give specific suggestions for the classroom teacher to follow in his relationship with the speech, hearing, and language handicapped child.
5. To assist in the orientation of new clinicians into this organization.
6. To incorporate acceptable standardized forms to insure an adequate and continuing record-keeping system for each individual program.
7. To serve as a source for materials, equipment, names and addresses of publishing companies.

PHILOSOPHY

The personnel in the speech therapy field at C.E.S.A. #5 will change during the next few years. The methods used by speech clinicians will fluctuate as will the children on the case load each year. Thus in developing a philosophy for speech therapy the clinicians must be idealistic as well as realistic in their viewpoints in order to include all these changes.

This is accomplished by adopting the basic philosophical statement of Mr. Vern Smith, State Supervisor of Speech Correction, "that adequate amounts of appropriate therapy must be provided for the speech handicapped child." This statement, as interpreted by the C.E.S.A. #5 clinicians, focuses on two key terms -- adequate and appropriate.

Adequate therapy engulfs the concept that the speech handicapped child must receive the amount of therapy which will insure him of success, whether this involves two twenty minute sessions, five thirty minute sessions or ten fifteen minute sessions of therapy each week. This means that the clinician is not concerned with whether or not each school building received equal therapy time or with dividing the day into convenient twenty minute blocks of time. Instead, the individual child and his needs are the primary concern.

The determination of appropriate therapy follows easily if a clinician gives adequate time to each child. Time is necessary to adequately diagnose the disorder, understand the child and the effect of the problem upon the child, and determine the method which is best for that child. Appropriate Therapy involves using a variety of techniques during a given

day. Appropriate therapy means utilizing knowledge and continually acquiring new knowledge about children and their problems.

This philosophy has been adopted by each of the C.E.S.A. #5 clinicians. Each clinician must examine and evaluate his program in relation to this statement to insure that each program continues to serve speech handicapped children.

PROFESSIONAL RESPONSIBILITIES OF THE SPEECH CLINICIAN

When an individual accepts the position as a public school speech clinician, he is also accepting certain responsibilities. These responsibilities vary according to the situation in which the clinician is involved. However, there are some general responsibilities that most clinicians must consider. Knowing and understanding these responsibilities helps the clinician in developing and maintaining good rapport with administrators, teachers, parents and other individuals involved.

The public school speech clinician should become aware of the existing rules his school or schools have established regarding their teacher and student responsibilities. Usually the schools will provide handbooks containing information pertinent to the clinician's situation. The public school speech clinician is a specialist and in many instances does not follow the guidelines used by the classroom teacher, however, the basic responsibilities do coincide, such as observing the days in which his scheduled schools are in session and following established school hours.

The most important responsibility of the speech clinician is to the students involved in his thereapy program. He schedules them for adequate amounts of therapy and he uses the method which will help the child attain success. The clinician keeps accurate records of each child for his own reference and for others who may seek information to evaluate a students special needs.

Each child's parents is informed when their child is to be scheduled

in the therapy program. Parents are informed of the nature of the child's problem and of their part in helping the child acquire the desired results. The parent's wishes are regarded as it involves their child. Involving other parents of the community in the program is essential. The news media and parent informational meetings are a means of relating to the public their role in the speech therapy programs.

The responsibility to the administration and classroom teacher is another concern of the clinician. The clinician is responsible for keeping his administrator or administrators well informed as to the therapy schedule, changes in the schedule, absent days, professional meetings, and any problems that may arise. The administrator is closer to the situation in his school and often can help correct or avoid any conflicts or problems the clinician may find. When scheduling his students, the clinician works with the classroom teachers to construct the most satisfactory schedule possible for both the teacher, clinician, and the child. The child's daily schedule is respected by the clinician in order to avoid any serious conflicts. The speech clinician keeps the teachers informed of their students progress and offers advice or suggestions that may be helpful in aiding the student. In most instances the classroom teacher is not trained in speech therapy but the clinician respects their observations and discusses or explains any differences in opinions regarding a child's needs.

It is the responsibility of the clinician to see that all students in his program receive a hearing screening evaluation. The results of the evaluation can be discussed with the principal, nurse and any other individuals concerned. The procedures for referring any child further

for special evaluation such as otologic examinations or psychological testing are determined by the school officials and the parents of the child under consideration.

The clinician is responsible for any school equipment he may use. Often facilities provided for the school speech clinician are quite limited, but still should be kept in the best possible condition. Any equipment failure or other damage should be reported to the proper personnel.

The speech clinician has a responsibility to himself to keep informed as to new ideas and techniques being attempted in his field. This is accomplished by attendance at professional meetings and state and national conventions, through reading magazines or published articles concerning speech therapy and by enrollment in workshops and graduate courses.

Wisconsin speech and hearing clinicians are certified by the Department of Public Instruction and are therefore bound by certified requirements and professional standards established by this department. It is therefore the clinician's responsibility to maintain these professional standards.

PROFESSIONAL ASSOCIATIONS

American Speech and Hearing Association

The American Speech and Hearing Association (ASHA) is an international professional association for Speech Pathology, Speech Science, Clinical Speech Therapy, Public School Speech Therapy, Audiology and Hearing Rehabilitation. It provides its members and related associations with many services. It certifies members who desire it, it publishes the major papers of its members in its three journals and it provides programs for professional sharing of research at its annual convention. Membership requires a Masters Degree or equivalent in Speech Pathology or Audiology. A Code of Ethics, established by ASHA, is followed by each member of the organization.

Wisconsin Speech and Hearing Association

The Wisconsin Speech and Hearing Association (WSHA) is affiliated with ASHA. It is comprised of members from the State of Wisconsin. Non-ASHA members can belong to WSHA, thus providing a professional association for public school speech clinicians who have their Bachelors Degree.

WSHA holds two annual meetings. The Fall meeting is in cooperation with the Wisconsin Education Association meeting in Milwaukee. The Spring convention (usually the first Friday and Saturday in May) is devoted to a two day program of professional papers, workshops, and demonstrations.

WSHA does not certify members, but recognizes ASHA Certification Standards, requiring a Masters Degree or equivalent for membership. A professional with a Bachelors Degree may be an associate member.

RESPONSIBILITIES OF THE ADMINISTRATION TO THE SPEECH THERAPY PROGRAM

The superintendent and the board members of any given school district can expect certain qualifications and standards from the clinician serving their schools. Likewise the speech clinician should be able to assume that certain standard procedures and facilities necessary for the success of the speech therapy program will be provided by the school administration.

The clinician should be familiarized with all the aspects of school procedures and policies. This can be accomplished by issuing the speech clinician a handbook at the start of the school year. The clinician should be introduced to the faculty as a fellow faculty member whose services are made available for speech handicapped children and for furthering the over all educational program for each child and his needs.

Adequate facilities necessary for a speech program should be available. The following discussion is a guideline for establishing a speech therapy program in the public schools. More detailed description of facilities and equipment will be given elsewhere in this handbook.

A room should be provided which is readily available to the students with good ventilation, lighting and of a suitable size for small groups. The room should contain a table and chairs suitable to the size of the children in therapy, a mirror, blackboard, bulletin board, tape recorder, and an auditory trainer. A locking filing cabinet and desk are necessary items. The portable equipment mentioned here can be shared by other departments, however, on the days that the clinician is at that building, this equipment should be in the therapy room.

A speech clinician is a trained professional whose qualifications should be recognized and accepted by all personnel of a district. Therefore, in the matters of screening, scheduling, selection of case-load, and the number of students enrolled in therapy, the decision should be left entirely to the judgment of the clinician.

Usually the clinicians employed by C.E.S.A. #5 serve more than one school district. Therefore an open line of communication is necessary to keep the clinician informed of the occurring events at each district. It is recommended that each district provide a mailbox for the clinician, make certain that the weekly bulletin is given to the clinician, and issue a school calendar indicating days of professional meetings, in-service training, parent teacher conferences, vacation, and the commencement and termination of the school year. If there are any deviations from this schedule it is the administrations responsibility to inform the clinician of the change.

It is important to the clinician to keep a speech evaluation on each child in a district. This is accomplished through the annual screening of the lower elementary grades. Through this record a clinician is always aware of the children in the district who are in need of therapy. When new students enroll in school during the school year, it is recommended that the administration inform the clinician by a written form so that this child's speech can also be evaluated. If a new students records indicate that he has previously been enrolled in speech therapy, this information should also be given to the clinician immediately so that therapy can be resumed as soon as possible. All students unable to be scheduled for therapy will be placed on a waiting list which then, as stated by

the Department of Public Instruction, becomes the responsibility of the administration.

Since the speech therapy program is an integral part of the educational process, the administration should be interested in the program and the clinician's effectiveness with children. It is hoped that each administrator when invited to observe the clinician, will do so at a time that is convenient to all concerned.

RESPONSIBILITIES OF THE CLASSROOM TEACHER TO THE SPEECH CLINICIAN AND THE SPEECH THERAPY PROGRAM

The classroom teacher has certain responsibilities to the speech clinician and to the school's speech therapy program. Observance of these responsibilities helps to insure the success and overall betterment of the child's communicative processes. The responsibilities of the classroom teacher to the speech clinician and the therapy program are:

1. To inform the speech clinician about any continuing or new students in their classes who may be eligible for speech therapy.
2. To provide an accepting classroom atmosphere, conducive to the acceptance of individual differences.
3. To consult the clinician about any questions they might have concerning therapy sessions and/or the progress of an individual student.
4. To realize that the determination of the case load and its size, ultimately is the responsibility of the clinician.
5. To understand that the speech clinician serves not only their school, but others as well, and therefore needs their full cooperation and support to assure a successful program.
6. To share information related to the child's personality, health problems, or behavior problems and to work with the speech clinician for the overall improvement of the child's personality, self-concept, and especially, in this case, communication skills.

ORGANIZATION OF THE SPEECH THERAPY PROGRAM

The speech therapy program can be divided into definite phases which form an outline of the school year. Under each individual clinician these phases are stressed differently and each one does not follow the form presented here. For example, some clinicians may screen one grade for determination of all the speech, hearing, and language problems at the end of the school year rather than the beginning of the school term. Also, some clinicians may write a semester progress report on each child as well as the final progress report. These decisions depend on the plan which works most efficiently for the clinician.

The first weeks of the school year are spent screening and testing the children with known or suspected communication disorders. This period of time offers the classroom teachers the opportunity to refer any students whom they wish to have evaluated. It must also be pointed out that these teacher referrals can be made at any time during the school year. Students moving into the school district during the previous year or the summer months also need to be screened. At least one of the lower elementary grades is involved in a complete screening program. This is carried out so that any of the students who have been overlooked by the teacher referrals will still be diagnosed by the speech clinician. This screening may involve a picture or sentence articulation test, an examination of the oral mechanism, a screening audiometric evaluation, and an informal assessment of the childs language abilities. This screening most often involves the entire second or third grade because by this age the maturational process of the central nervous system necessary for

correct articulation has been completed. Screening and the subsequent re-testing of those failing the initial screening may take as long as four weeks. The amount of time required is dependent upon the number of children involved and the comprehensiveness of the screening program. A thorough screening program is necessary for an adequate therapy program. In an ideal set-up, a complete screening of the entire school system would be conducted every five years or even more frequently if there was a rapid turn-over of clinicians. The screening of all grades insures the recognition of all students with even a slight speech or hearing handicap. With careful organization and cooperation from the administration and teachers, this complete screening can be handled quickly and efficiently.

After the necessary testing program those children needing speech, hearing, and language therapy are selected and scheduled for therapy. The selection of the caseload is the total responsibility of the speech clinician and he uses his best professional judgment as the final criteria for placement on the active caseload. The State of Wisconsin, Department of Public Instruction sets very flexible standards concerning the size of the caseload. It suggests that justification of inclusion on the schedule should be based on the kind and/or degree of severity of the speech handicap. The prognosis for remediation and the age of the child is also considered. It further suggests that therapy be offered as often as is necessary for the child to successfully correct the speech problem. Too frequently speech therapy given just once a week merely enables the child to recognize the fact that he has a problem, but does not provide sufficient time for him to do anything to correct the problem. Thus the

speech clinician carefully determines which children are handicapped by the speech or language deficit. This involves consideration of the effect that the problem has on the educational, social, or psychological development of the child. Pre-school children and the mentally retarded children are also the responsibility of the speech clinician. Therapy cannot cease after eighth grade for many students, so it is necessary to include secondary students in the caseload.

The speech therapy program is a part of the total educational program for the speech, hearing, or language handicapped child. With this principle in mind it is evident that therapy is not secondary to reading, art, music, etc., but is equal in importance. In close cooperation with the classroom teacher each clinician will attempt to determine the time allotment which is best suited for the child. It is helpful for scheduling purposes if the local administrator has a master plan for the various itinerant programs within the school district available for the clinician on the opening day of school. The building principal should be consulted during the process of scheduling. The child's wishes are considered when scheduling as some children would be very unhappy and perhaps even uncooperative if they were scheduled during a favorite class period. With all of these factors to be considered, it is evident that scheduling can often be very difficult and time-consuming.

The clinician will schedule sufficient time for any travel between school buildings when necessary. Breaks during the school day are necessary to enable the clinician to continue at an efficient pace.

Children are generally scheduled for a period of fifteen to thirty minutes for from one to five sessions a week in individual or small group

therapy. Here again the age and severity of the problem is considered. A Kindergarten or pre-school child may only be able to attend for fifteen minutes while a high school stutterer may need a forty-five minute session. A child on carry-over activities may only need to be seen bi-monthly while a mentally retarded child with delayed language may need to be scheduled five days a wekk.

The State Department of Public Instruction also suggests that there should be some unscheduled time in every program. This unscheduled time or "office hours" is held on Friday afternoon at C.E.S.A. #5. This time is necessary for contact with parents and professional people such as nurses, social workers, psychologists, and other clinicians. Diagnostic testing, hearing testing, revising schedules, planning for therapy, maintaining records, in-service meetings, studying cumulative folders and observing certain children in the classroom, are other activities which make an office afternoon a necessary part of the program. The schedule is given to the administrators after it is completed. Those children who cannot be scheduled for therapy, but are in need of the services, are placed on a waiting list. The schedule remains flexible during the entire year as changes are necessary because of conflicts with the child's academic progress or the dismissal or addition of students during the year.

When an administrator or teacher observes several therapy sessions, it is evident that many methods of therapy are used; however, all of these methods follow the basic principles of learning. Each session is carefully planned with all activities directed toward specific objectives. Some clinicians use a modified lesson plan form or anecdotal record sheet and

all have methods of recording the results or observations for each day. Self-evaluation is an essential part of the therapy procedure. During each session there is a constant awareness of the child's psychological needs. There are long range and short range goals involved and the ultimate goal is the best speech the child can be helped to produce. This end results may take months or years for the child to achieve. Each therapy session reflects the clinician's individual philosophy and beliefs.

The final week of the school year is devoted to the writing of progress reports and other record-keeping activities. These progress reports and other records are important as they insure continuity for the speech therapy program from year to year. Reports are given to the parents and to the teacher for inclusion in the child's cumulative folder. These reports are written during the final week of the school term and the forms used in C.E.S.A. #5 can be found in this handbook.

COMMUNICATION DISORDERS FOUND IN THE SCHOOL

Speech is spoken language composed of articulated vocal sounds ordered in words and sentences so as to reveal the ideas of the speaker to the listener. Hearing is the ability of the listener to receive the spoken symbols of the language by the speaker. Speech and hearing are parts of the learned process referred to as language. Language is an organized system of linguistic symbols (words), used by human beings to communicate on an abstract level. Communicative disorders refer to problems of speech, hearing, and language involving both the speaker and the listener.

I. Disorders of Articulation

The most common communication disorder that the teacher encounters in her classroom is defective articulation. Speech surveys in the schools have generally indicated that approximately three out of every four speech problems belong in this group. Children with articulation disorders do not produce all of the speech sounds in the usual, accepted manner and may be difficult to understand or even unintelligible. Misarticulations range from a single distorted sound to multiple sound errors.

The speech errors take one or more of several forms and are grouped under three classifications: omissions, substitutions, and distortions. Omissions (such as when a child says top for stop) occur more commonly in the speech of younger children and when severe enough, render a child's speech almost unintelligible. Substitutions of speech sounds (such as wam for lamb and thun for sun) are common in young children

and often are inconsistent; that is, the sound is produced correctly in one word and no in another. When occurring in older children, substitutions are more consistent. One of the common substitutions among school age children is the use of the th in place of s or z. This is called a frontal or central lisp. Distortion errors such as the slushy s sound produced when the air escapes over the sides of the tongue occur with greater frequency than omissions in the speech of older children and adults. Here, the correct sound is approximated, but is not acceptable. A child with an articulation problem then, is one not able to produce consistently and effortlessly the ordinary, accepted sound patterns of speech.

The question of why some children do and some do not develop correct articulation is a troublesome one for parents and teachers and is often difficult to explain. The following outline, as stated by Johnson, Brown, Curtis, Edney, and Keaster in Speech Handicapped School Children gives some ideas as to the reasons why some children develop defective speech patterns:

A. Constitutional factors
    1. Dental abnormalities
    2. Other oral irregularities (tongue, palate)
    3. Auditory factors
B. Faulty Learning
    1. Poor speech models
    2. Lack of stimulation and motivation
C. Emotional Maladjustment
D. Intelligence

The question of why some children are seen by the speech clinician and others are not may also come up. One reason is that a child may not necessarily need to have certain sounds in his repertoire for his level of maturity. Another reason is that some forms of speech habits will probably profit more from speech improvement and encouragement by the classroom teacher than by direct involvement in speech therapy.

The role the classroom teacher plays in the overall success or failure of a speech therapy program is significant. He or she spends more time with those children enrolled in speech therapy, therefore, they play an important role in aiding the clinician in stabilizing the new sounds the children learn in the therapy session. Through their reading classes, class participation activities, and other subjects, the classroom teacher can reinforce the students use of the newly learned sound or sounds.

The following are some basic principles that classroom teachers might follow to promote the use of the correct sound productions in their room:

1. Begin by having the child use his new sound" during reading, thus giving the child a visual cue as well as an auditory cue.
2. Don't correct the child every time he makes an error, but make him aware of your interest in his good speech.
3. Expand this interest from reading to include other areas of classroom activities.
4. Gradually increase the consistency of his use of the new sound in all classroom activities.
5. Praise the child for his efforts and encourage him to use the sounds"all the time".
6. Please do not hesitate to contact the speech clinician if there are any questions about procedures or any individual students you may have.

The following timetable is an estimate of the child's developmental progression during the acquisition of speech and language.

NORMAL SPEECH DEVELOPMENT FROM BIRTH TO 8 YEARS OF AGE

Age Months	General Characteristics	Approx. No. Voc. words	Approx. Sounds artic.
1	reflexive crying due to basic needs		
2	vocalizing becomes more differential: babbling and cooing.		
3	Smiles-cooing and babbling continue		
4	Continued babbling-sounds becomes an attention getting device.		
5	More specific vocalization shows displeasure as well as pleasure.		
6	Increase in amount of babbling.		
7	Begins lalling or moving his tongue during vocalization.		
8	Shows recognition of people and objects through vocalization.		
9	Echolalia-imitates sounds heard. Begins combining syllables.	1	
12	Continuing Echolalia-jargon begins. first word usually appears about this time.	1-3	vowels
18	Jargon becomes more fluent. Use of one word sentences begins.	18-22	
Years			
2	Child begins naming people, objects and places. He has gone to two word sentences and is beginning to use, me, and I.	300	

Years	General Characteristics	Approx. No. Voc. words	Approx. Sounds artic.
2½	Sentences have expanded to three words.	450	h, w, hw
3	The child's speech has become intelligible and he uses it to relate stories, experiences or needs to others.	900	p, b, m
3½	Normal speech dysfluencies expresses concepts with words. 4-5 words used in complete sentences.	1200	t, d, n
4	Motor development continuing at a rapid pace. Fantasizes, very verbal	1500	k, g, ng
5	Language structure and form are complete. Child begins to use more abstractions and more complex sentences.	2200	f, v
6	Speech clear and intelligible. Begins to read.	increasing	l, r, y s, z, sh
7	Sentence structure becomes increasingly complex.	increasing	ch, zh, j
8	Normal articulatory development should be complete.	increasing	th (voiced and unvoiced)

II. Hearing Impairments

It is estimated that 5% of school age children have hearing levels outside the range of normal and that one or two of every ten in this group require special education. Speech problems associated with impaired hearing are revealed chiefly in certain distortions of articulation and voice. The hard of hearing child cannot hear the speech of others well enough to imitate accurately, and cannot monitor his own voice sufficiently to know that he is making particular errors. The degree to which speech is affected depends generally upon the requencies affected, the severity of the impairment and whether the impairment occurred before or after the age of two years.

Hearing handicapped losses vary in extent and type. In terms of extent, children are divided into three groups:

(1) Children whose hearing loss is slight, (as much as 20 decibels below normal intensity with zero being normal).

(2) Children whose losses are moderate to severe, (as much as 40 decibels below normal intensity).

(3) Children whose losses are severe, (60 decibels or more below normal intensity).

Early detection and diagnosis of losses of children in group 1 help to prevent their joining the ranks of groups 2 and 3 later on.

There are basically three types of hearing losses. When an abnormal condition exists in either the external or the middle ear, a conductive type of hearing loss sometimes results. In this type of hearing

loss there is an interference of the passage of sound from outer to inner ear, such as that caused by wax impacted against the eardrum or by middle ear infection. A typical conductive type of loss reduces the loudness of all tones or sounds by an equal amount, as though all the speech heard sounded like it was coming from the next room with the door closed. Often a child with this type of loss talks very softly since he hears his own speech louder than he hears the speech of others.

The second type of hearing loss is that caused by damage to the auditory nerve. This type is known as a sensori-neural or inner ear impairment. Such a loss is sometimes existent from birth or it is sometimes due to disease or injury. An inner ear impairment typically affects high pitched sounds lik s, sh, ch, more than the low pitched sounds. The child hears these only with increased loudness; therefore these sounds are frequently omitted or distorted in the speech of a child with a nonconductive loss. The voice of a child with this type of hearing loss is often abnormally loud and the pitch is frequently very monotonous. He has a tendency to shout in order to hear his own voice as well as possible. In general, he shows a much more serious speech problem.

A third kind of hearing loss is a combination of conductive and nerve loss and is referred to as a mixed loss. The middle ear may have become defective through some chronic condition which also has affected the auditory nerve.

Often a classroom teacher can discover a hearing deficient child in her room simply by taking note of the following:

The child breathes through his mouth more than normally expected.

Has frequent earaches and running ears.

Hears nosies in his head.

Has a peculiar sounding voice.

Fails to articulate correctly certain speech sounds or he omits certain consonant sounds.

Gives the wrong answers to simple questions.

"Hears" better when watching the speaker's face.

Is functioning below his potentional ability in school.

Has frequent upper respiratory infections like sinusitis and tonsilitis and has allergies similar to hay fever.

Has become a behavior problem at school and at home.

Gives poor attention.

Holds his head to the side to catch the sound with the better ear.

Confuses words with similar vowels but different consonants.

Is withdrawn and does not mingle readily with classmates and neighbors.

Many suggestions are offered to help the teacher deal more effectively with the hard of hearing child in the classroom. The speech clinician will provide the classroom teacher with a pamphlet from the Department of Public Instruction titled "Assisting the Hearing Impaired in the Classroom", upon request.

One more hearing problem which has not thus far been described is that of the deafened child and the deaf. In the deafened child a child had normal hearing through the period when he was learning speech and language, but he was stricken with a disease such as meningitis which destroyed his hearing. He often is sent to a special school to continue

his education. The deaf child is the child who did not have sufficient hearing at the time when speech normally develops to be able to learn to imitate speech through auditory media. He was not able to learn speech through imitating what he heard, and he reached school age without the ability either to articulate or to understand speech. Occasionally a kindergarten or preschool teacher may have a child with such a problem in her classroom. In such case, the teacher with the help of the speech clinician, can help the parents to understand why the child must have special education.

III. Delayed Speech and Language Disorders.

Delayed speech is a general term which refers to the fact that a child has not acquired speech at the expected time or with the expected accuracy, In using delayed speech and language as a classification term, one must know the normal development of speech and language. This is found in a chart provided in this handbook. This delay can be caused by hearing impairment, damage to the central nervous system, mental retardation, emotional disturbance, environmental deprivation or immaturity. It is the responsibility of the speech clinician to determine the cause of the delayed speech and language and then determine the degree of the delayed speech and language. Immaturity presents an additional challenge when it is the cause of the delayed speech and language because the immature child may be evaluated at a time when he is just mastering the fine coordination necessary for the production of certain sounds but his speech is presently unintelligible. This results in inaccurately labeling the child as this disorder may be outgrown. Delayed speech and language involves disorders of articulation, sentence structure, and vocabulary.

The child with a language disorder has not developed the pre-requisites or thought processes necessary for a language system. It is stressed that a culturally disadvantaged child does not have a language disorder, but rather, he has a language deviation. This child uses the language of his own culture which definitely is a language system.

Successful therapy in the area of language disorders if contingent on careful differential diagnosis. A thorough case history covering the pre-natal, birth, and post-natal periods is a primary requirement. The clinician also obtains information concerning this disorder through systematic observation in structured and unstructured situations. These observations include such things as general attitude toward surroundings and other people, attention span, fine and gross motor coordination, sentence length, extent of vocabulary, appropriateness, sentence order, perceptual skills as well as numerous other responses.

The specific diagnostic tests given to a child do not lead to a label, but rather enable the clinician to discover the strengths and weaknesses of the child's language system. It is nearly always possible through remedial techniques, to strengthen the weak areas and enable the child to function with an adequate level of communication.

IV. Stuttering

Stuttering is a phenomenon which has held the interest of speech clinicians since the beginning days of the profession. This problem is so complex, so undefined, so contraversial, and therefore, challenging. Stuttering is a combination of many attitudes and behavior problems. It is caused by multiple conditions and/or circumstances that vary greatly in their implications for treatment among individuals. Stuttering

responds best by varying the treatment to fit individual needs. So, you see, stuttering is by no means a simple, concrete problem to describe or understand. However, a few of the more basic things known about this problem will be discussed.

The estimates of incidence of stuttering differ according to survey procedures and definitions of stuttering, however, it is generally found that from 7% to 1% of the school population have this problem.

The characteristics of stuttering are true for all speakers at some time. All people are non-fluent at some occasion. The fact that makes the difference is the awareness or concern of this non-fluency. Stuttering usually has its onset during the preschool years. Many theories of causes have been tested and they are:

1. Lack of cerebral dominance.
2. Differences in overall constitution.
3. Neurological differences.
4. Psychological conflict.

Learned behavior.

Behaviorists theorize that stuttering is learned and that there is no physical difference between stutterers and nonstutterers. It is created by listeners who mistake normal fluency disruptions for beginning signs of stuttering. In showing excess concern, the adult might, unknowingly, pass on to the child feelings of frustration and self-consciousness about himself. However, some children do develop stuttering when there is no evidence of abnormal reaction to it also.

Stuttering sometimes is classified into different groups according to

severity. The first group, although not actually considered to be stuttering by many, will be mentioned here because the concerned parents or adults often do consider it a real problem. This is the type of behavior seen in children with relatively mild, though excessive or frequent repetitions and prolongations who are completely unaware or unconcerned about the broken speech. When a parent is very concerned, counseling to overcome fears and to avoid diagnosing this problem as stuttering is helpful. Such counseling alleviates the probability of the child turning into a "stutterer".

The other group consisting of advanced or confirmed stuttering, is labeled secondary stuttering. It is seen in those with more noticeable forms of the disorder that developed after they began to react emotionally to breaks in fluency of their speech. In this group exists a wide range of characteristics and personality types. The children in this group are those beginning to have difficulty in some situations and with certain listeners, starting to avoid certain words, having difficulty in response to particular sounds, and using tricks or devices such as eye blinking to help in fluency.

One of the most important ways to help a child acquire more confidence about his speech and help his speech to improve is by cooperating with his teacher. Working as a team is profitable for everyone involved with the problem. Information from the teacher and the clinician can be shared to guard against an unwise course of action. In order to help the teacher to know a little more about the problem of stuttering, some general information and suggestions will be provided by the clinician on request.

V. Voice Disorders

Disorders of vocal production represent a small percentage of the cases diagnosed and treated by speech clinicians. Approximately 1-2% of all school age children present significant voice problems. In some children voice problems are organic which is the abnormal condition of the vocal mechanism and in others the structure of the vocal mechanism appears all right but it fails to function adequately. Normal voice quality is one which is appropriate in loudness, pitch, flexibility, and quality. Disorders of loudness are those in which the voices are deficient in audibility or poor projection and in extreme cases there is a loss of voice. On the other hand, there are some with voices which are too loud, usually a result of a hearing defect. Disorders of pitch occur when the general highness or lowness of the voice is unusual or inappropriate to the age and sex of the child. Disorders of flexibility are associated with monotonous voice with little variation in pitch or loudness. The four disorders of voice quality (nasal, breathy, hoarse, harsh) are the most frequently occuring voice disorders. Nasal voice qualities occur when the individual talks through his nose. Denasal quality is the result of no nasal emission during talking which sounds as though the person has a stuffed nose. A breathy voice has a whisper effect. A hoarse or husky voice sounds as though the individual has a bad cold which affects the larynx (often vocal abuse). A harsh voice quality has an unpleasant, rough, and rasping sound.

Inadequate voices may be caused by organic abnormalities affecting the various organs of the vocal mechanism. Although conditions affecting the larynx are rare in children, occasionally a severe chronic hoarseness will indicate such a condition. This child is then referred to a physician. Organic abnormalities of the mouth cavity such as a cleft palate, may affect the voice. Another organic cause of voice disorders is that resulting from enlarged adenoids. Here, due to the obstruction of the adenoids, the child has difficulty breathing through his nose and therefore may have a denasal voice.

Voice disorders not accountable for in terms of organic causes, are classified under functional problems including the following:

1. Psychological maladjustment
2. Difficulty in controlling the adolescent voice change.
3. Poor breathing habits
4. Imitation of poor habits

Not all children with vocal deviations are included in the caseload. The main reasons for this are that the need for securing medical attention may delay or prevent therapy and the voice may not actually interfere with the intelligibility of the child's speech.

The role of the classroom teacher in helping with voice problems is just as important as in any other case. She can provide the encouragement needed for motivation. When new voice habits are being transferred to connected speech, the same steps as those mentioned for helping children with articulation problems should be followed. Assistance of this type is of the greatest necessity, since, without

it, the speech clinician cannot insure that good speech habits are made part of the child's everyday speech.

VI. Speech and Language Disorders Associated with Cleft Palate and Cerebral Palsy

Mixed types of speech problems include those associated with cleft palate and cerebral palsy. Deviations of articulation, rhythm, or language may occur. Only about 1% of the clinicians caseloads are children with cerebral palsy and approximately 2% are children with cleft palate conditions.

Cleft palate and/or cleft lip is a difficulty associated with development of the embryo in which a disruption of normal fusion occurs causing either a cleft of the palate, palte and lip, or only the lip. The speech of a cleft palate child is often nasal and often has articulation disorders due to faulty structure. Clefts of the palate are repaired surgically or fitted with a prosthesis.

Although no teacher is likely to have many cleft palate pupils during her career, she may encounter a few. With these few, it is extremely important that they be made to feel "at home" with the other children. To prevent ridicule and rejection, the teacher may have to explain to the other children why the cleft palate child talks as he does. Also she may need to offer help and understanding directly to the child. The teacher can help the speech clinician by providing behavioral information and information about his speech in the classroom, carrying through some of the remedial activities which the clinician begins, and helping the child to use these activities in the classroom.

Cerebral palsy, resulting from brain damage, denotes impairment of motor function controlling muscle coordination. Although the child

with cerebral palsy may have one or a number of associated conditions, such as visual problems, hearing problems, or mental retardation, it is the impairment of muscle control that distinguishes him from other groups of handicapped children. Speech is defective in about 70% of the cases. In general, the speech is slow, jerky, and labored. The voice tends to be monotonous and uncontrolled and articulation suffers because of the impaired muscular coordination.

The more severely handicapped cases of cerebral palsy will not be found in the regular public school classrooms. However, when a teacher does have a cerebral palsied child in her classroom, she can help the speech clinician by supplying information about how much and how well the child is talking in the classroom and other important behavioral aspects. She can often work directly on the child's speech under the supervision of the clinician. It should be remembered that the cerebral palsied child often needs to have things made easy for him physically, and frequent opportunities to relax.

REQUIRED FORMS

The use of these forms is required of all Speech Clinicians employed by Cooperative Educational Service Agency #5.

SPEECH AND HEARING REFERRAL FORM

The Speech and Hearing referral form is a triplicate, no carbon required form that must be filled out by the referrant. No verbal referrals should be taken. The "Basic Information" and "Referral Information" sections are to be filled out by the referrant before the child is seen. The "Evaluation" section is filled out by the clinician after completing a diagnosis of the child's problem.

The original copy of the form is to be kept on file by the clinician. The next copy is sent back to the referrant to be put in the childs academic cumulative folder. The final copy is sent to the principal, to inform him of the students tested and their status. Enough copies should be given to the building principal to enable him to fulfill all requests for referral forms.

SPEECH AND HEARING REFERRAL FORM

I. BASIC INFORMATION DATE_____

NAME_____BIRTHDATE_____

SCHOOL_____GRADE_____INSTRUCTOR_____

PARENT'S NAME (full name)_____

AODRESS_____PHONE_____

_____

_____

II. REFERRAL INFORMATION REFERRANT_____

1. Reason for Referral (Describe Problem)

2. How has the problem affected his school achievement?

3. Additional information pertinent to the problem.

_____

_____

III. EVALUATION DATE_____

DIAGNOSTIC TEST RESULTS:

RECOMMENDATIONS:

ACTION TAKEN_____

PARENTS CONTACTED_____NO_____YES (date contacted)_____

Signed_____
Speech Clinician

(Speech file copy)

MASTER SPEECH AND HEARING CARD

This 4 x 6 card is to be kept in the C.E.S.A. #5 central file as a record of all students seen in the program. The form is to be filled out on All students seen whether on your case load or seen only for diagnosis.

The information can be copied by the office secretary from the Speech and Hearing Referral Form. This form can be turned in the afternoon the clinician is in the office and be picked up later that day of the next scheduled work day at the office.

Note: This form is found on page 47.

SPEECH OR HEARING EVALUATION ROSTER

Any screening of a specific class or grades must be recorded on the evaluation roster. Three copies are to be made. The clinician is to keep the original, give one copy to the instructor of the class evaluated and a copy to the building principal. The form is self explanatory.

SPEECH OR HEARING EVALUATION ROSTER

School_____ Teacher_____

_____Speech _____Hearing Grade_____Room No._____

Screening Date_____ Diagnostic Test Date_____

Name of Child Last First	Screening Results		Diagnostic Test Results		
	Adequate	Retest	Adequate	Retest	Remarks

COOPERATIVE EDUCATIONAL
SERVICE AGENCY NO. 5
SPEECH AND HEARING SERVICE

NAME_____BIRTH DATE_____

ADDRESS_____TELEPHONE_____

CITY_____COUNTY_____STATE_____

SCHOOL_____PARENTS NAME_____

REFERRAL_____

SUMMARY EVALUATION_____

DISPOSITION_____

CLINICIAN_____

(Code: WHITE, Public; GREEN, Parochial; CHERRY, Other)

Note: Directions for this form are found on page 43.

SPEECH THERAPY FILE SUMMARY

This form is to be used as a face sheet in all file folders kept on students in the program.

The form is self explanatory.

COOPERATIVE EDUCATIONAL SERVICE AGENCY NO. 5
Elmwood, Wisconsin

Speech Therapy File Summary

Name: _____
(Last) (First) (Middle)

Birthdate: _____ Sex: _____ Initial Contact Date: _____

School: _____ Grade: _____

Parent Contacted: _____ Date: _____

Name of parent: _____ Phone: _____

Address: _____

Referral source: _____

Diagnostic interview by: _____ Date: _____

Diagnostic findings: _____

_____

Recommendations and disposition: _____

_____

Therapy Record

Began Mo./Yr.	Clinician	Day/Time	Terminated Mo./Yr.	Disposition	Comment

SPEECH THERAPY PROGRESS REPORT
(Two Versions)

The Speech Therapy Progress Report is to be filled out on all students still in the therapy program at its termination. There are two forms, the short form for routine cases and the long form for the cases needing a more detailed explanation. Either form can be used, however, one of the forms must be used. The short form is self explanatory. The long form is explained in detail on the following page. Two copies are to be made, one copy is to be placed in the speech file and the other in the academic file.

SPEECH PROGRESS REPORT

NAME_____ SCHOOL_____

GRADE____ AGE____ BRITHDATE_____ TEACHER_____

NATURE OF SPEECH IMPEDIMENT:

HEARING	_____
ORGANIC	_____
ARTICULATION	_____
ORGANIC AND ARTIC	_____
FOREIGN OR REGIONAL DIALECT	_____
LANGUAGE	_____
STUTTERER	_____
DELAYED SPEECH	_____

VOICE QUALITY

NASAL	_____
DE-NASAL	_____
HOARSE	_____
HIGH PITCH	_____
LOW PITCH	_____
NORMAL	_____

DATE THERAPY INITIATED:_____

SOUNDS WORKED ON_____

THERAPY PROCEDURE FOR

CLINICIAN'S IMPRESSIONS OF CHILD'S ATTITUDE

	Yes	No	Sometimes
Likes to come to speech	___	___	_____
Shows an interest in group participation	___	___	_____
Shows a personal interest in his work	___	___	_____
Wants to correct his sounds	___	___	_____
Works well during therapy situation	___	___	_____
Takes pride in oral communication	___	___	_____
Completes work on time	___	___	_____

PSYCHOLOGICAL TESTING: NO ( ) YES ( ) (REFER TO PERMANENT FILES)

SPEECH AND LANGUAGE TESTS ADMINISTERED: (REFER TO PERMANENT SPEECH FILES)

RECOMMENDATIONS:

Enroll in therapy in the Fall. _____
Recheck in the Fall and if necessary re-schedule_____
Dismiss permanently._____

SPEECH CLINICIAN_____
DATE_____

SPEECH THERAPY PROGRESS REPORT
(Long Form)

This form is to be used when a detailed explanation of the case is desired. The following information must be included on this form:

1. Diagnosis
2. Tests administered
3. Summary of methods used
4. Results of methods used
5. Impressions of attitude
6. Prognosis
7. Recommendations

The form must be signed by the Speech Clinician. Two copies are made, one copy for the speech file and one for the cumulative academic file.

SPEECH THERAPY PROGRESS REPORT

NAME_____ BIRTHDATE_____

PARENTS NAME_____ ADDRESS_____

SCHOOL_____ GRADE_____ INSTRUCTOR_____

SPECIAL EDUCATION EXPENSE ACCOUNT CLAIM

This form is to be filled out once a month on the Friday before the fourth Monday of each month. All mileage for agency business is to be recorded for reimbursement. Any other expenses incurred by the clinician for agency business should be cleared by the Special Education Coordinator.

COOPERATIVE EDUCATIONAL SERVICE AGENCY NO. 5
Special Education Expense Account Claim

From _____ To _____ Home School _____
(Date) (Date)

Date	Where to	Miles	Other
	Totals		

_____ miles @ _____ cents = $_____

Grand Total = $_____ SIGNED _____

SPEECH CORRECTION REPORT
(DPI)

The Department of Public Instruction (Bureau for Handicapped Children) requires all speech clinicians to file a state report before November 15th. This two page report is to be filled out in triplicate and is to include all students in the program. The original form is to be submitted to the Bureau for Handicapped Children. The second copy is for the superintendent of your schools and the third copy is for your own records. Your weekly schedule listing all cases by problem, (not name), the time and the days, is to be filed with this report.

NOTE: This report is due November 15th. Please submit original to Bureau for Handicapped Children with your schedule. The second copy is for filing with your Supt. and the third copy for your own records.

SPEECH CORRECTION REPORT

Department of Public Instruction
Bureau for Handicapped Children
126 Langdon Street
Madison, Wisconsin 53702

_____
SCHOOL DISTRICT (Name & No.)

_____
(Signed) Speech Clinician

PLEASE GIVE THESE TOTALS: (all must be filled out)

I. a. Total for all public school enrollment, kindergarten through 6th: _____
b. Total for all public school enrollment, 7th, 8th, and 9th grades: _____
c. Total for all public school enrollment, 10th, 11th, and 12th grades: _____
d. Total enrollment for all private schools that you serve: _____
e. Please give total enrollment for ONLY the schools that YOU serve: _____

II. SPEECH LOAD B = Boy G = Girl

GRADE	STUTTERS		DELAYED SPEECH		VOICE DISORDERS		ARTICULATORY DEFECTS		IMPAIRED HEARING		OTHERS (list)		TOTALS	
	B.	G.	B.	G.	B.	G.	B.	G.	B.	G.	B.	G.	B.	G.
Kdgn.														
1														
2														
3														
4														
5														
6														
7														
8														
9														
10														
11														
12														
Total														

III. Give your weekly schedule. Include the name of the schools serviced, the time for each group, and groupings, or individuals for each period. (List the pupils by the nature of their problem rather than by name.) Example: Monday A.M. Lincoln School 9:00-9:30 6 articulatory cases; Monday A.M. Lincoln School 9:30-9:50 1 stutterer

IV. List the number of children seen: once a week_____, twice a week_____, three times a week_____, four times a week_____, five times a week_____, and more_____. (This total must equal grand total of Section II, Speech Load).

V. SPECIAL SERVICES: Do you participate in or offer services to: (to what extent)....
A. Hearing Conservation Program? _____
B. Mentally retarded? _____
C. Other special handicapped children? _____
D. Speech improvement? _____
E. Parent conferences? _____

VI. Do you have any questions concerning the organization of your work? Any other questions?

_____

Gretchen N. Phair and Vernon J. Smith
SUPERVISORS OF SPEECH CORRECTION

SPEECH CORRECTION REPORT
(DPI)

This is the second page of the state report to be filed by November 15th.

FACILITIES PROVIDED FOR SPEECH CORRECTION

(Name of Speech Clinician)

Directions: Please evaluate each school you service using this key: M = more than adequate
(Use as many columns as you need for the schools you service) A = adequate
Please give names of the schools. I = inadequate

	School I	School II	School III	School IV	School V	School VI
I. WORK AREA: (Please give description of): A - Location of work area:						
B - Accessibility for children:						
C - Privacy (interruptions):						
D - Sound Proofing:						
II. ROOM CONDITIONS: A - Ventilating:						
B - Heating:						
C - Electrical Outlets:						
D - Lighting:						
III. ROOM EQUIPMENT: A - Bulletin board						
B - chalk board						
C - Mirror						
D - Table (right size for child)						
E - Chairs(right size for child)						
F - File case						
G - Storage space						
IV. OTHER EQUIPMENT: Tape recorder						
Audiometer						
Others (please list)						
V. SUPPLIES: Such as books, papers, duplicating materials, etc.						
VI. COMMENTS:						

DISMISSAL INFORMATION FORM

The Dismissal Information Form is used for each childs termination of therapy. The information is filled in and given to the secretary to update the office copy of the Master Speech and Hearing card. The information is also used to compose a letter to the parents to inform them of their child's release.

DISMISSAL INFORMATION FORM

STUDENT'S NAME _____

SCHOOL _____

ADDRESS _____

PARENTS NAME AND ADDRESS

_____

_____

_____

REASON FOR DISMISSAL _____

HOW LONG IN THERAPY _____

DISMISSAL DATE _____

SPEECH PROBLEM _____

CARBON COPIES TO: _____

_____

SPEECH CLINICIAN

SUPPLEMENTARY FORMS

The forms in this section are available for use by the Speech Clinician but they are not required.

DEPARTMENT OF PUBLIC INSTRUCTION
SUMMER SPEECH CORRECTION FORMS

The forms for the operation of a summer speech therapy program consist of the following:

1. The Plan of Services for Summer Speech Correction Services must be completed one month before beginning the summer session.
2. Report on Summer Speech Session must be completed before the end of the second week of the session.
3. The Final Report of the Summer Speech Session is due before the final pay check.

These forms are to be completed in triplicate. The original form is sent to the Bureau for Handicapped Children, the second copy is sent to the Administrator of the school in which the program was conducted and the third copy is for the clinician.

SCHOOL DISTRICT

PLAN OF SERVICES FOR SUMMER SPEECH CORRECTION SERVICES

(To be filled out at least one month before beginning of summer session)
(This will require joint planning by the administrator and the person conducting the program)

I. ADMINISTRATION

A. Building Facilities:

Name of building _____ Address _____
Number of rooms _____ What rooms _____
Room equipment (tables, chairs, bulletin board, chalk board, etc.) _____

B. Schedule:

Summer session begins _____ until _____ for _____ days per week.
Daily sessions begin _____ A.M. until _____ P.M.
Lunch period: _____ A.M. until _____ P.M.
Length of therapy sessions: Individual _____ Group _____
How many times a week will each child enrolled receive therapy _____
Will parent observe every session? A few sessions? No sessions? (Underline one)
Are you planning any daily full morning or afternoon therapy sessions for a particular group of speech handicapped children? _____

C. Teaching Equipment:

Audiometer _____ Tape recorder _____
Other equipment _____

D. Transportation: (We are interested in transportation but do not have funds available

a. Does the speech correctionist travel to various centers? _____
If yes, what time is planned for traveling? _____
b. If the child travels, how is this arranged? _____
c. If the child must wait, what provision is made for the waiting period? _____

II. PHILOSOPHY

What reasons do you have for justifying this program? _____
Were referrals made? _____ If so, by whom? _____
Was a survey done? _____ If so, who conducted the survey? _____
Will parents be charged for this service? _____ If so, what amount? _____
Are students attending private schools during regular school year eligible for summer Speech Correction Services? _____

III. PERSONNEL

NAME	TRAINING (Where, what degree, when)	SALARY	CERTIFICATE HELD
		Annual Salary _____ S.S. Salary _____	

Date _____ Signed _____
Administrator

This plan approved by _____ _____
State Supervisor State Superintendent

Date _____ BY _____
Assistant State Superintendent

Exceptions:

(Keep one copy. Use same number for each child on final report Use additional pages if necessary.)

II

From: _____
Speech Clinician

REPORT ON SUMMER SPEECH SESSION

(Due before end of second week of session)

_____
School Dist., City

NAME OF CHILD	BIRTH DATE	SCHOOL ATTENDING	GRADE THIS FALL	SPEECH PROBLEM	WHY CHOSEN FOR SUMMER SPEECH
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					
17.					
18.					
19.					
20.					
21.					
22.					
23.					
24.					
25.					

III

From: _____
Speech Clinician

_____
School District, City

FINAL REPORT OF SUMMER SPEECH SESSION
(Due before final pay check)

NAME OF CHILD	Attendance			Use this space for: (1) If this child dropped out, why? or (2) How did this child benefit from the summer speech therapy?
	No. of times	Length of periods	Individual or Group Therapy	
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				
21.				
22.				
23.				
24.				

SPEECH AND HEARING THERAPY SCHEDULE

This is a copy of a schedule that can be used to organize the program. When completed, copies can be given to the Administrator of the school participating in the program. This form is a suggested form, however, the clinician may utilize any other form.

COOPERATIVE EDUCATIONAL SERVICE AGENCY NO. 5
SPEECH AND HEARING THERAPY SCHEDULE
196__ - 196__School Year

Therapist_____

Day	Time	School	Student	Speech	Hearing	Teacher	Grade	Disposition of Case

MEDICAL REFERRAL RECORD

This form is used when a medical evaluation is necessary for completion of the diagnosis. This referral is made in cooperation with the Principal or the School Nurse.

Cooperative Educational Service Agency No. 5
Elmwood, Wisconsin 54740

MEDICAL REFERRAL RECORD

REFERRAL Date_____

Name of child_____ Birth date_____
Last First Day Mo. Yr.

Parents name_____ Phone_____

School_____ Grade_____

Reason(s) for referral_____

_____

_____

_____

_____

_____

Referred by_____
Signature Title

EVALUATION

MEDICAL REPORT

Diagnosis:

Medical Treatment (or Recommendations) Given:

Prognosis:

Examining Physician_____
Signature Address Date

PHYSICIAN, PLEASE RETURN THIS FORM TO:

_____
Name Title Address

EQUIPMENT AND MATERIALS

In 1967, the American Speech and Hearing Association established basic room and equipment criteria for a school speech therapy program. These requirements were endorsed by the Wisconsin Speech and Hearing Association in May, 1969. The writers of this handbook have adopted these criteria for the therapy programs which they represent. In addition to the therapy room itself, the clinician needs an office with satisfactory equipment, secretarial assistance, available duplicating equipment, a private conference area, and an annual budget for improving facilities and equipment. A mail box assigned exclusively for the speech clinician should be provided in each individual building served. Listed below are the necessary facilities and equipment for an adequate speech therapy program.

ROOM

Location	In a relatively quiet area near administrative unit with accessiblity to classrooms, waiting area, secretarial services, and other special service personnel.
Size	150-250 square feet to be used primarily (or ideally, exclusively) for speech and hearing services.
Number	One room, ideally with an adjoining office.
Lighting, artificial	60-75 foot candles
Lighting, natural	At least one window with shade, ideally with drapes.
Heating	Adequate heating, ideally with thermostatic control.
Ventilation	One window which can be opened, or air conditioning.

Acoustical treatment	Acoustical treatment of ceiling doors, and walls, ideally draperies and carpeted floors.
Electrical power supply	One 110V double plug on each wall. Ideally a rheostatic mechanism to facilitate use of audio-visual equipment.
Intercom	Ideally, one intercom unit, connected to administrative offices.
Chalkboard	One 3' x 5' (approximate) mounted on wall at appropriate height for pupils.
Bulletin Board	One 3' x 5' (approximate) mounted on wall.
Mirror (s)	One 3' x 5' (approximate) mounted on wall at appropriate height for pupils. Should be able to be covered.
FURNITURE	
Desk	One office desk
Chairs, adult	At least two chairs.
Chairs, child	Sufficient number of student school chairs to accommodate pupils at various grade levels.
Table	One table adjustable in height to accommodate pupils at various grade levels.
Equipment stand	One stand on casters suitable for tape recorder, record player, etc.
STORAGE FACILITIES	
Storage space	Locked storage space
File case	Locked file cabinet.
Bookcase	Bookcase with 4'-8' (approximate) linear space.

EQUIPMENT

Audiometer	Properly calbrated portable audiometer available.
Auditory training equipment	Individual amplification units available according to need.
Tape recorder	One assigned for exclusive use by the clinician (including mic. with 500-1000 CPC range, Hi-Fi reception).
Phonograph	One 3-speed phonograph available in building.
Telephone	One telephone, ideally a direct outside line.
Typewriter	Available.
Electric clock	One.
Wastebasket	One.

OFFICE SUPPLIES

Stapler, staples, scissors, reams of paper, file folders, envelopes, carbon paper, typing paper, paper clips, scotch tape, etc.

DIAGNOSTIC TESTS

The speech clinician needs various tests for purposes of determining the child's problems and needs. Without these tests the clinician cannot plan the proper speech program for each individual child. Among these are tests of articulation, auditory discrimination, language, and vocabulary. A short description of each type of diagnostic tool will follow.

Tests of articulation are used to determine which sounds the child may or may not be using at the appropriate times. Is he, for example using a good (s) phoneme (sound) at the beginning, the end, and/or in the middle of words, or in specific blends.(st. sk, spr, etc.) of that sound. Do the misarticulations occur in isolation, syllables, words, sentences, and/or in reading or talking? This test helps to indicate the type and the position of the misarticulation.

Some articulation tests determine only gross errors of articulation and are used for screening. Often it is the only articulation test required to determine a child's speech problem. Other times it is only the first of many. Other tests, such as the McDonald Deep Test of Articulation, are longer and take more time to give. These tests are used to pin-point a more specific articulation problem and are of great use to the speech clinician in planning a child's speech program

The Templin-Darley Screening and Diagnostic Test of Articulation includes a short and long form as well as normative data. The Goldman-Fristoe enables the clinician to test phonemes in isolation, words and contextual speech. The Predictive Screening Test of Articulation allows the clinician to determine which sounds will be corrected through the maturational process.

Tests of auditory discrimination are used to investigate the sounds the child is hearing properly. If one does not hear the sound correctly he most likely will not produce it correctly. The most commonly used tests of auditory discrimination are the Wepman, Templin, Boston, and the Goldman-Fristoe-Woodcock.

Tests of vocabulary -The Peabody Picture Vocabulary Test with the two test forms is a valuable evaluating instrument for the speech clinician. The PPVT can test the vocabulary level of an individual from the ages of three years and three months through eighteen years. The testing is done in a nonverbal manner; a response may be indicated in a variety of ways (pointing, etc.). The tables included in the test manual make possible the conversion of the raw score to intelligent quotient, mental age and percentile, all of which are reliable.

LANGUAGE TESTS

The Houston Test for Language Development differs from other language tests in that it is the only instrument which can measure and evaluate the spontaneous language of a child in the span of a testing period. The author has chosen objects such as a doll family to get more spontaneous reactions from the child with less adult participation. These reactions are then evaluated objectively by comparing such things as temporal content, syntactical complexity, and sentence length with the norms for each age group. Other items on this test include Vocabulary, Body Parts, Gesture, Serial Counting (automatic speech) and Object Counting (involving concept), Repetition of Speech Patterns and Geometric Designs (testing the ability to imitate), and Drawing (testing the ability of the child to retain auditory instruction). This test provides a language scale for age levels of three to six years.

The Illinois Test of Psycholinguistic Abilities allows the speech clinician to gain an objective look at the language level of a child from 2-6 to 10-0 years of age. This test differentiates the areas of deficiency and makes it possible to easily establish remediation procedures. Ten sub-tests and two supplementary tests evaluate the automatic and representational levels of psycholinquistic abilities using the auditory-vocal and visual-motor channels of communication. This test requires a well-trained administrator and takes approximately one and one-half hours to give.

As more research is done on language and learning disorders, more

evaluative techniques will be developed. It is also recommended that certain parts of other standardized tests can be useful as part of the testing battery for language disorders.

Each clinician develops his own materials and has his own preferences for the materials which have been published. One of the main topics of discussion among clinicians is new ideas for materials or materials that are successful for a certain type of disorder. Rather than specifically listing activity material in this handbook, the clinician can obtain catalogs from the publishers as listed in the appendix.

APPENDIX

PUBLISHING COMPANIES AND ADDRESSES

DIAGNOSTIC MATERIALS

American Guidance Service, Inc.
Publishers Building
Circle Pines, Minnesota

Boston University School of Education
Speech and Hearing Center
332 Bay State Road
Boston, Massachusetts

Bureau of Educational Research & Service
Extension Division
State University of Iowa
Iowa City, Iowa

Consulting Psychologists Press
577 College Avenue
Palo Alto, California

Cooperative Research Project No. 1538
Charles Van Riper
Western Michigan University
Speech and Hearing Center
Kalamazoo, Michigan

Institute for Research on Exceptional Children
University of Illinois
Urbana, Illinois

Psychological Test Specialists
Box 1441
Missoula, Montana

Stanwix House, Inc.
3020 Chartiers Avenue
Pittsburgh, Pennsylvania

THERAPY SOURCES

Alexander Graham Bell
Assoc. for the Deaf
The Volta Bureau
1537 35th St. N.W.
Washington, D.C.

American Guidance Service
Publishers Building
Circle Pines, Minnesota

American Hearing Society
1800 H Street, N.W.
Washington, D.C.

Anthony School Equipment Co.
4143 North Bartlett
Milwaukee, Wisconsin

Arnold, Miss Genevieve
University of Houston
Houston, Texas

CEBCO
Educational Division of
Standard Publishing
P.O. Box 31138
Cincinnati, Ohio

Cenco Educational Aids
2600 S. Kostner Avenue
Chicago, Illinois

Children's Record Guild
27 Thompson Street
New York, New York

THERAPY SOURCES CONT.

Council for Exceptional Children
1201 16th St. N.W.
Washington, D.C.

Creative Playthings
5 University Place
New York, New York

Di-Bur
Box 1184
Pueblo, Colorado

Expression Company
Magnolia, Massachusetts

Go-Mo Productions
Waterloo, Iowa

Houghton-Mifflin Company
Boston, Massachusetts

Ideal Speech Materials Assoc.
6218 South Albany Avenue
Chicago, Illinois

Instructo Products Co.
1635 N. 55th Street
Philadelphia, Pennsylvania

Interstate Printers and Publishers
Danville, Illinois

King Company
4609 N. Clark Street
Chicago, Illinois

Milton Bradley Company
Springfield, Massachusetts

Speech and Language Materials, Inc.
P.O. Box 721
Tulsa, Oklahoma

Speech Materials
Box 786
Starrs, Connecticut

Stanley Bowmar Co., Inc.
Volhalla, New York

Stanwix House, Inc.
Pittsburgh, Pennsylvania

Talkalong Products
Box 444
Monterey, California

Teaching Resources, Inc.
334 Boylston Street
Boston, Massachusetts

Warren, Jay L. Inc.
1247-49 Belmont Avenue
Chicago, Illinois

Webster Publishing Co.
1808 Wabash Avenue
St. Louis, Missouri

Whitehaven Publishing Co.
Box 2
New Richmond, Wisconsin

Whitman Publishing Co.
Racine, Wisconsin

Word Making Productions
Box 305
Salt Lake City, Utah

EQUIPMENT SOURCES

Ambco Electronics
Los Angeles, California

Bell and Howell
Language Master Dept.
7100 N. McCormick Road
Chicago, Illinois

Beltone Electronics Corp.
4201 W. Victoria Street
Chicago, Illinois

EQUIPMENT SOURCES CONT.

Eckstein, Bros.
Hawthorne, California
(Gordon N. Stowe, Distributor)
1728 Chapel Court
Northbrook, Illinois

HC Electronics, Inc.
Tiburon, California

Maico Co., Inc.
Maico Building
Minneapolis, Minnesota

Standard Projector & Equipment Co., Inc.
Chicago, Illinois

Telex
9600 Aldrich Avenue South
Minneapolis, Minnesota

Zenith Radio Corporation
Department 35Y
6501 W. Grand Avenue
Chicago, Illinois