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The Development of the Home and Hospital Program of the Chicago Public Schools, 1899-1985

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LOYOLA UNIVERSITY CHICAGO

THE DEVELOPMENT OF THE HOME AND HOSPITAL PROGRAM OF THE CHICAGO PUBLIC SCHOOLS: 1899-1985

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BY
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VITA

The author, Vivian Edith Rankin, was born in Chicago, Illinois.

Her elementary and secondary education was obtained in the public schools of Chicago, Illinois. She received a Bachelor of Education from Chicago Teachers' College and a Master of Arts from Northeastern Illinois University. She has certificates in General Administration and Supervision, Administration and Supervision of Special Education, teaching certificates in early childhood, elementary and secondary education, as well as teaching of the physically handicapped, mentally handicapped, trainable mentally handicapped, learning disabled and behavior disordered.

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INCEPTION

Introduction

In the late 1800s there were no educational programs to meet the needs of children handicapped by poor health and physical problems. Indeed, only a few medical practitioners cared for them. The developing technological, medical and educational advances, interrelated with the social awareness of the time, created a climate in which several groups turned their attention to improving the conditions of these children. It is the intent of this work to explore and trace the development of the Hospital and Home Teaching Programs of the Chicago Public Schools for these children.[1]

First of all, this work will describe early hospital teaching programs that laid the foundation for the provision of educationally based services to children with orthopedic and other health problems. These programs in hospitals and homes were extended to provide service within schools. The demarcation between medically and educationally based services were at times blurred, but eventually cooperative efforts developed between regular and special educators and the medical profession in improving the services children. In addition, some of the cooperative efforts between the private and public sectors of the city in their continuing efforts to provide for handicapped children will be reviewed.

Pioneers in this area of special education laid a foundation on which programs have been developed to provide for the complex needs of handicapped children and those with chronic health problems. Repeated requests from medical staff and parents spurred the initiation of homebound instruction and other program additions and changes over time. Difficulties will be reviewed as reduced funding forced administrators to reassess the service model while attempting to provide mandated services to eligible students.

Finally, suggestions for future efforts will be briefly presented in consideration of the effects of a complaint filed with the Office of Civil Rights. This forced attention on a neglected program which began with such optimism.

Pediatric Care In Chicago: Early Attempts

Dedicated in 1882, the Maurice Porter Memorial Hospital For Children was established to provide free medical care for the sick. This private dwelling originally provided for eight beds. By 1895 it had grown to accommodate twenty-two. This was a very small contribution since the estimated number of homeless children in the city at that time was ten thousand. The number of children receiving inadequate medical care was estimated to be several thousand.[2]

Dr. John Ridlon, a prominent orthopedic surgeon reported in 1890 that "there was no general hospital with an orthopedic service and no special hospital for the treatment of crippled children . . . ." However, by 1892, the Chicago Children's Hospital and Mission to the Destitute began providing services to youngsters with orthopedic problems. Although a significant step forward, they had only seven or eight inmates limited to those below eleven years of age.[3]

In June 1892 "a mass meeting was called to organize a society to provide a home [hospital] for crippled children." Officers were elected and preliminary steps taken to organize the Building and Aid Society of what was to become the Home for Destitute and Crippled Children. On 28 November 1892 a charter was obtained from the Secretary of State. Organizational efforts continued and on 26 January 1893 the charter and the assets and obligations of the Chicago Children's Hospital and Mission to the Destitute were surrendered, and the Home for Destitute Crippled Children became a reality.

On 27 January 1893, a public meeting was held at the Central Music Hall of Chicago to gather support for the project. About 1,500 were present. Thirty-six auxiliary societies were formed in various parts of the city, and in May nearly three thousand were members. Mrs. Emma Steele, president of the society, reported that in the month before the meeting she had made over 500 calls to prominent citizens interested in charity work. Included in this number were representatives of many religious denominations. At that January meeting $1,000 was donated to finance this important work.

Dr. John Ridlon, affiliated with Rush Medical College, was appointed Medical Director and Consulting Orthopedic Surgeon of the home. He reported that they had identified many children, all of whom required some specially devised apparatus for support or care. He maintained that "any assertion that these children [could] receive proper care in the general hospitals arises from a profound lack of knowledge of the exigencies of the situation." He insisted that "the Home must provide for the care of the diseases and deformities of the inmates as well as other necessities." To this end the home employed a nurse and a matron. Orthopedic consultation was provided twice weekly. A record of the child's condition and specific treatment recommendations were maintained in a chart. The home was in every sense a hospital.[4]

Dr. John B. Murphy was consulting surgeon, and Dr. Walter S. Christopher was consulting physician for Disorders of Children. The medical staff included Dr. Frank Billings, Dr. E. F. Ingalls, and Dr. W. H. Allport, as well as others. The pediatric patients of this hospital received needed ophthalmology, neurology, dermatology, and dental services as well as orthopedic and general medical care.[5]

Property was purchased at Park Avenue and Paulina Street. Records indicated the cost to have been $30,000, with an outstanding debt of $24,000. It was a two story brick house with a large attic and basement. It was remodeled to include a reception hall, assembly room, office, school room, matron's room, one dormitory, and a day nursery on the first floor. Five large dorms, a medical board room, and a nurses room were on the second floor.

The Home for Destitute Crippled Children opened in October 1893. Applications were received daily and children were admitted as rapidly as possible. Initially they had twenty-five applicants, and accepted twelve. The others were being investigated. Only applicants who could benefit from treatment were admitted or allowed to remain. Mrs. Edward Delano, secretary, reported that they would eventually care for forty to fifty children.

The first patients, ages six to sixteen, were suffering from tubercular disease of the neck and hip, leg length discrepancies, tuberculosis of the hip or lower half of the spine, liver disease, and kidney disease. One child was paralyzed and one was an amputee. The children came from two other hospitals; Mrs. Pullman's Home at Wildwood and Cook County Hospital.

The by-laws of the Home for Destitute Crippled Children included the following specific goals for the patients:

1. To give the inmates the necessities and reasonable comforts of life.

2. To restore the use of limb and facility, or to mollify the suffering of the incurable as much as can be done by the skill and wisdom of the

most able and distinguished surgeons and physicians.

3. To enlarge and improve the mental capacity by a system of practical and judicious education under experienced and competent instructors.

4. To develop by careful training, so far as may be possible, any talent an inmate may have for handicraft, that may tend to cultivate individuality, give a purpose in life, and make the individual at least partially self-supporting.

5. To give all children at the home two hours of instruction each morning.

Children of any race, nationality, or creed were accepted upon the recommendation of the Committee on Admissions. Children under three, boys over twelve, and girls over fifteen were not admitted. Epileptics, "imbeciles" and children with contagious diseases were also excluded. There were plans to include the remodeling of a large two story barn into a school facility. This was eventually done and connected to the house with a covered passage enabling the children to go to school in any weather.[6]

The work of the Society For The Home For Destitute Crippled Children was viewed as ". . . Christ-like charity. Destitute, crippled, children; what a trinity that is," said Adeline C. Sherwood, president of the home in 1894. She extolled the virtues of "noble-hearted women, who have well-nigh literally taken their lives in their hands, going out into the by-ways and alleys to seek out and try to save the poor little victims of misfortune and suffering . . . . Angels even are denied such blessed, unselfish and heavenly ministries."[7]

This attitude of charitable work extended to the two teachers who were now working with the children in the hospital school. The financial reports for that year indicated no expense for salaries. The only item shown was a request for kindergarten supplies in the amount of $22.07. The home was supported by contributions of the many benevolent societies, and by volunteer workers.[8]

Since the separation of church and state and its educational ramifications had not yet been defined by the courts, there was non-sectarian religious instruction for an hour each Sunday afternoon. These Sabbath exercises were intended to "bring out and brighten and deepen much that was innately good and true" within the children.[9]

The First Hospital School Program

The Constitution of the State of Illinois provided for the education of all children under twenty-one years of age. The goal of the school program at that time was the "leading out" all the powers (abilities) of the child. Therefore, everything which would best unfold the child's mental, physical, and moral powers should be used in the education of children."[10]

The annual report of the home indicated that the children received daily instruction from competent teachers, and as soon as possible "such industrial training as the taste and capacity of the child and the means and accommodation of the Home will permit."

By 1895, kindergarten had become an established feature of the educational program of the home. The regular education program was modified to meet individual needs, but the essential features were retained by the teacher. The annual report noted:

> that although we can scarce expect in a class of suffering little ones like ours to produce many brilliant scholars, yet there are some minds among them that scintillate with the fires of true genius. Their physical infirmities overcome, or at least lightened, and with the key to the universe and its mysteries placed in their hands, life may become to them one sweet, grand song. . . .To all, whatever their mental equipment, such intellectual food will be given as their minds can readily digest, and no child will be permitted to remain in ignorance of the fundamental principles of knowledge.[11]

The aim of the school was defined as "to help on a healthy, purposeful growth, thus preventing as far as possible the disease of mind and character which seems sometimes to be the natural outgrowth of a diseased body." Hospital records of that year, indicate that "seventeen children went out . . . cured of their deformities . . . twelve to the extent that they were no longer being called cripples."[12]

In 1899, Mrs. Sherwood, President of the Society of the Home for Destitute Crippled Children, defined the work of the institution. Their purpose was to provide the most effective charitable work for children. They meant to provide each child with a broad "foundation for a useful Christian citizenship. Education is the watch-word of all intelligent thought, the key-note of all wise effort in behalf of children." She continued to say that "education had always stood only second in importance to that of the physical reconstruction of our little ones in this Home." Mrs. Sherwood reported the children in the home are "children whose mental status is that of the normal, although many seem to be above the norm . . . that was due to the suffering which often causes to shine with a new and increased light the latent fires within." The annual report for this year reiterates that the primary purpose of the home was the healing of patients, but following a sound body was that of a sound mind which must be developed.[13]

During the year 1899, a cooperative effort was begun with the impetus being provided by a member of the board of the home. This woman, the wife of President Andrews of the Chicago Board of Education (1898-1900), provided the "power behind the throne." With her intervention, the board of education quickly adopted the school program of the hospital. Now the children of the home received the same advantages offered to the other students in the city. The school of the home became part of the public school system and the teacher salaried.[14]

Medical Investigation of Children

The interest in the physical well-being of all children began extending into the public schools when Dr. Walter S. Christopher was appointed a member of the board of education. As a member of the Committee on Child Study and Scientific Pedagogy, he recommended a plan for making anthropometric observations on the children in the public schools. The board adopted the recommendation and the investigation was started under the direction of Dr. Christopher assisted by Mr. C. Victor Campbell, an evening school principal, and Mr. Fred W. Smedley, a teacher of child study at the University of Chicago.

The project began in March 1899 at the Alcott School. This school was selected because it "contained what may be called normal children." The children were from homes of "comfortable circumstances being well-fed and well-clothed children of American birth." The information gathered was standardized, and the individual results were recorded for each pupil. Reports indicated that the pupils were eager to be examined; their attitude toward the tests was likened to that of a "competitive spirit that would be found in games."[15]

The teachers were cooperative in hopes of gaining a more positive knowledge of individual pupils. The summary report indicated that those pupils who made the "greatest intellectual progress were generally taller, heavier, stronger, and possessed of greater endurance and breathing capacity."[16]

At the suggestion of Superintendent Andrews, the tests were also made on pupils in an ungraded room at another public school. A number of developmental defects were found including microcephaly, cranial asymmetry, visual defects, and malnutrition. Poor muscle tone was noted in seven of the sixteen children. The averages of all children in the ungraded room were lower than the children at the Alcott School.

The report concluded that there was a clear relationship between physical condition and intellectual capacity. Recommendations were that physical condition be made a factor in the grading of children for school work and that classes in physical culture should be graded on a physical instead of an intellectual basis.

The final report noted that, "the needs of the pupils in ungraded rooms are complex, and bear careful investigation of each child." Many of the recorded defects were indicated to be nutritional. These included anaemia, starvation, fatigue, and toxaemia. Motor defects were to be managed through the constructive work and educational games now used increasingly in the schools. But at this time the remaining problems were considered to be outside the scope of the school system.

Dr. Christopher noted "since it is the duty of the state to educate all children, . . . this work must not be conducted as guess work." It must be soundly based on scientific information. He recommended that the physical examinations of children be continued under the board of education and made a permanent feature of the investigation and consideration of each child.[17]

Mr. Henry Suder, Supervisor of Physical Culture reported that "principals and teachers are more and more convinced that the same attention should be paid to bodily as to mental education." The physical basis of education became a subject of increasing study during the school year 1898-99. It was believed that the "confinement of children in the unnatural environment of the artificially heated school rooms for periods of ten months prohibit[ed] the vigorous development and growth of many children."

The <u>Chicago Record</u>, in cooperation with the board of education, provided a series of lectures in school assembly halls. The topics reflected the growing interest in improvement of the health of all citizens. These included, "Child Growth," by Bayard Holmes, M.D., "Food and Dietetics," by Dr. Otto Folin, "The Cost of Preventible Diseases," by Dr. Holmes, and "Tuberculosis," by Dr. W. A. Evans. The total attendance at the lectures was about forty thousand.[18]

Schools for Crippled Children

In May 1900, Mr. Brennan, Chairman on the Committee On School Management, presented a report recommending that the superintendent of schools be asked to "formulate a special type of education to be given to crippled children." In addition, the report recommended that "an omnibus line be established to carry crippled children from their homes to and from the school". This decision was based upon information received from Mrs. Emma Haskell, teacher in charge at the Home for Destitute Crippled Children, and from Mr. W.L. Bodine, Superintendent of Compulsory Education. A list of crippled children residing within a radius of two miles around the building was included.[19]

To alleviate the overcrowding in the home, the board of education entered into a lease of the upper floor of the building. The annex was to be maintained as a school for crippled children who were inmates. This hospital school became a branch of the Emerson School. In June 1900, The Committee on School Management recommended that the branch be made an independent school and that Mrs. Emma Haskell, the present teacher, be placed in charge.

Soon a recommendation was made to lease from the home, for a period of ten years, an area of land sufficient to erect a school for crippled children. The annual rental was to be only one dollar. Implicit in the agreement was the understanding that the children of the home would be the first to be "properly taught." Included in the lease was the understanding that the construction would be appropriate for the future use of the home. Use of the basement was maintained as an area in which braces and other devices for the children could be made.[20]

Temporary provision for the School for Crippled Children during the razing and new construction was made by renting space located at 571 W. Madison Street, at the corner of Ogden Avenue. This site allowed for future additional services to handicapped children. Consequently a second teacher, Miss Minnie Marquart, was assigned to the School for Crippled Children in January 1901.[21]

A report of the Compulsory Education Department, utilizing information gleaned from the biennial school census of 1900, revealed that a total of 153 crippled children were not attending the public schools. Recommendation was made that centers for the education of these children be established at the Knickerbocker and Agassiz Schools on the north side, and at the Dewey and the Fallon Schools on the south side. Additional sites were to be located on the west side at the established School for Crippled Children.

Mandatory physical examination by a physician under the authority of the board of education was recommended by the committee report. The physicians were "instructed to exclude all such pupils whose physical and mental state may be such as to render their attendance at schools undesirable." The Superintendent of Compulsory Education reported that thirty-three children were physically disqualified during the school year 1900-1901. Many of the children attending these schools were deformed with hip and spine diseases. It was hoped that many of the deformities could eventually be cured.[22]

The Omnibus Line

The Omnibus Line, established for the transportation of crippled children to the two centers of instruction, was reported to be the first free transportation system in the world maintained by a school system. In other cities, transportation was offered by charitable institutions. This service was for children unable to walk to and from school. The president of the board reported that transportation should be the obligation of the public school system and, as a result, four buses were put in service to take sixty-five children to and from school daily. Three buses served the West Side School and one the Fallon School. The average time for each route was one hour and twenty minutes. Many of the children had to be carried from the bus to the door of their home. Each bus was provided with an attendant whose responsibility was to provide for the "personal care, comfort, and safety of the children." These routes were maintained, accident free, for the ten month school year. During the winter, closed heated buses were used. In spring and early summer, open wagons were utilized.[23]

An additional bus was authorized in January 1902 due to the number of children waiting placement at the Schools for Crippled Children. It was to transport children to and from the Fallon School. The chief of police assigned six officers as drivers of the buses to ensure the safety of the children.[24]

Supplementary transportation services to the West Side School for Crippled Children, were subsidized by the <u>Chicago American</u> in April 1902. This payment, in excess of $400, allowed that amount to be redirected to the regular transportation fund for crippled children. The cost of the transportation for the school year was $266.59. It was justified in that these children would not have been able to attend school without such service. As a result they would grow up in ignorance and would become burdens for future taxpayers.[25]

Instructional Program

Rigid grading in the school was not possible or desirable due to the disabilities of the pupils. Intellectual and physical differences resulted in a "backwardness due to various causes" and necessitated a careful study of each individual and the adaptation of the work to individual needs.

In addition to providing the regular curriculum, emphasis was placed upon "industrial training," so that pupils could become self-sustaining and enjoy some measure of independence. It was "hoped that this industrial training would make them good and useful members of society." Both boys and girls, ages ten to twelve, were required to have instruction in sewing, darning, crocheting, fancy needle-work, basket-making and other construction work. Music and games were included in the school day in an attempt to "brighten the lives" of the children.[26]

Emma Haskell, teacher in charge of the West Side School for Crippled Children, reported that the number of students had increased from seven to fifty-three by 1901 and an additional twelve children were waiting for service. In May, 1902, the temporary housing of the West Side School for Crippled Children was abandoned and the school moved to newly renovated quarters on the first floor of the Tilden School. This allowed for the addition of another staff member and the inclusion of more pupils. The total enrollment at Tilden was sixty-seven pupils, with thirty-two at the Fallon School. Nevertheless, many children remained unserved due to the great distances they would have to travel in order to reach the current sites. The general superintendent of schools recommended the establishment of other centers in convenient areas of the city.

In order to improve the health and vigor of the students, additional nourishment was dispensed. Miss Haskell noted the charitable endeavors of Mrs. James A. Lawrence and Mrs. R. H. McElwee in the preparation of a hot luncheon which was served daily. It was reported that many of the philanthropists of the city were observing this experiment with a great deal of interest. Of special note was a weeks outing at Ravinia. For many of the children this was their first opportunity to view "trees, green fields, and farm animals." Miss Haskell observed that the improved health of the children was due to the care given them and to their "sanitary surroundings."[27]

Special one day outings were also planned. Trips were made to the Art Institute, various museums, the drainage canal, and to the country. In addition, the children were "entertained by a number of our citizens."[28]

Vacation Schools for Crippled Children

Observing the cooperative efforts between the board of education and social welfare groups, the superintendent of schools, in his annual report, proudly mentioned the vacation schools. Joint ventures allowed the board to support social movements and to supplement the educational programs as well.

On 26 June 1901, the secretary of the board of education received a communication from Miss Florence E. Prouty, teacher of crippled children at the Fallon School. She explained that she was offering her services for the summer at no charge and requested that the board allow the use of the school room and to fund the cost of the Omnibus to transport the crippled children to the vacation school. She explained that the children were "expressing regrets at the impending closing of school for the summer." Miss Prouty explained that many of the children came from homes of "little comfort and few pleasures." In addition, she said that "a daily ride in the open air, the care and guidance that may be given them in the school room and a day or two each week in the park with the birds and flowers would benefit these afflicted little ones .

. . . " The board granted the request and in addition appointed a janitress to the Fallon School to assist in the care of the children.[29]

The purpose of the vacation schools was to serve as an arena in which new ideas in education could be tried. Here city children experienced country life through excursions. In addition, the children were removed from the negative influences of the city streets during the vacation. The schools afforded a "pleasant cooperative occupation."[30]

In June 1903, the board allocated the first financial assistance to the vacation schools. Mr. William J. Bogan, Superintendent of the Vacation Schools Committee, requested the use of six sites and appropriate staff for the summer program. Included was the Crippled Children's Department at the Fallon School. Permission was granted to utilize both space and equipment at all sites.[31]

Summary

Although modest, the early efforts at the Home for Destitute Crippled Children provided the impetus for increased services to crippled students throughout the city of Chicago. The educational programs were offered initially by private institutions and then by public facilities that were adapted to house handicapped children. Chicago was the first school district in the nation to address the transportation problems of handicapped pupils by funding their own program.

The growing interest in the physical well-being of all students served to identify more and more handicapped students. More programs were initiated. In the following chapter that these growing numbers resulted in the planning and construction of a specially designed facility for crippled children.

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CHAPTER II

THE EARLY 1900s

Introduction

The early 1900s brought the Progressive Era and the growth of philanthropic groups such as the Chicago Women's Club. These groups were generally composed of community spirited reformers. Their activities were directed toward the continued improvement and refining of services to children. As a result, hospital treatment expanded, educational staff were specially trained for both hospitals and schools for crippled children, new schools were constructed, and programs were developed to meet the needs of more and more handicapped children.

New Service Agencies

One philanthropic group, the Children's Hospital Society, was incorporated in 1903. In addition to "promoting the extension of facilities for the care of sick and crippled children" and those with infectious diseases, it attempted to improve the functioning of the existing agencies for the care of such children. It served as a coordinating agency and referred children for urgently needed services to St.Luke's, Provident, Mercy, Wesley, Mary Thompson, Children's Memorial, The Home for Destitute Crippled Children and Presbyterian

Hospitals. A result of the influence and work of the society, the Cook County Children's Hospital, with 150 beds, was erected.[1]

"The social status of our country is being directed upon certain lines . . . the real Americans . . . [are] treading the progressive highway, confident in the nobility of their motives and strong in their consciousness of the presence of a guiding public opinion." Thus, Dr. Fernand Henrotin called for the creation of an improved hospital facility for the care of sick and crippled children. As president of the medical staff of the Maurice Porter Hospital, his recommendations were of great importance in improving the care of these children. He called for a separate building to provide for both medical and orthopedic surgical care. A physical training department to correct orthopedic problems and develop the weak, included a scientific laboratory and a hydrotherapeutic department.[2]

Within the schools, new procedures and activities were increasing the number of students identified as crippled. For example, in April 1903, rules were adopted for the medical inspection of pupils in the elementary schools. Inspectors were assigned to each of the twelve school districts within the city. Principals and teachers assisted in the selection of pupils to be examined. Referrals were based upon the recognition of physical deformities or retarded mental development. Except for cases of suspected infectious or contagious diseases, all examinations were preceded by the written consent of the parent or guardian. Examination results were provided to the principal for reporting to the parent. This included recommendations for further medical care or removal from school programs.[3]

During the school years 1905-07, scarlet fever and diphtheria were at epidemic proportions. The schools responded to the attendance problems by making referrals to the Compulsory Education Department and the visiting nurses. Over seven thousand students were absent from school for reason of illness or poverty within the family. The numbers of identified children in need of special programs grew.[4]

In their continued efforts to comply with the compulsory school legislation, the board of education initiated an intensive study of school attendance. The Compulsory Education Department, in cooperation with the Visiting Nurse Association, focused their investigation on non-attending children from eight selected schools. Their report was presented at a conference on truancy held in 1906. Records of students identified as absent for reasons of health were reviewed. As a result, many names were added to the list of students waiting to be admitted to the crippled children's school.[5]

In 1907, the Compulsory Education Department entered into an agreement with Archbishop Quigley of the Archdiocese of Chicago to extend the work of the department to every

Catholic school. Similar agreements were reached with all other parochial and private schools in the city. As a result, additional truant officers were employed and there was another increase in the number of students identified as suffering from health problems. Mr. Bodine noted that frequently "truancy . . . is traced to physical defects" which have gone untreated.[6]

Legislative Changes

Although the Chicago school programs for crippled and health impaired children had become an established tradition by 1903, in February, a board resolution was prepared for introduction to the state legislature in an effort to increase revenue. Noting that the state provided for the education of "deficient children," the resolution requested that the number of "deformed and crippled children in the city, be provided for as well."[7]

A period of intense lobbying resulted in legislation passed on 13 May 1903. The State of Illinois authorized school districts to establish and maintain schools or classes for crippled children in the public schools. An Illinois law enacted in July 1903, required that children between the ages of seven and fourteen attend school. Effective 1 July 1903, school districts could apply to the State Superintendent of Public Instruction for permission to maintain classes for the instruction of crippled children. These classes were for children ages six to twenty-one years of age. The average class size was to be not less than fifteen pupils.

School districts were reimbursed in the amount of $150 per pupil from the State Common School Fund upon annual submission of documentation. This payment was based on the assumption that the pupil received instruction for at least nine months of the school year. Hospitalized students were also included in this claim. In addition, if no appropriate school could be found in the district of residence for a student, this legislation required that the local school district pay tuition to other districts for allowing their pupils to attend.[8]

It must be noted that this legislation did not come without some opposition. Some argued that the public schools were for normal children and should not be used as asylums for the unfortunate. Some citizens objected to the high cost despite the largely philanthropic nature of much of the funding. Ultimately, these programs were accepted by the general public.[9]

Educational Staff

The legislation of 1903 provided some solutions but created other problems in the education of crippled children. Previously, teachers assigned to these special schools were not required by law to have a teacher's certificate. However, these appointees were now to have specific instruction in the teaching of crippled children for a period of not less than one year. These new educational requirements necessitated an immediate request for an exception because three teachers in the existing schools for crippled children were unqualified as the law was written. The assignment of a new teacher to the Mark Sheridan School for Crippled Children focused the attention of the board of education on their need to offer appropriate educational coursework for teachers.[10]

Coordinated efforts with the normal school created extension classes for teachers and other educational personnel dealing with crippled children. In December 1904, a prescribed course of study was established. Although conducted by the extension department of the normal school, the classes were funded by special authority of the board. The sessions were held at Northwestern University and medical staff of that school presented the lectures. Twenty-five teachers were enrolled in two courses conducted from January to June 1904. The courses were "Applied Anatomy and Corrective Exercises" and "Corrective Work." The plan involved future work in the study of diseases causing deformities, hygiene, and child study. The intent was to develop a group of teachers qualified to comply with the provisions of the state law regarding the instruction of crippled children.[11]

These opportunities for professional growth for "progressive teachers" allowed for the achievement of academic degrees and other certificates of attainment. To attract the older teachers, an inducement was provided in the form of increased salary for completed classes.[12]

Spalding School

By 1905, the existing programs at the Tilden, Fallon and Mark Sheridan Schools for Crippled Children were severely overcrowded. These schools were not constructed for special students and so the problems were compounded by architectural problems which made accessibility difficult or impossible for some students. Five classrooms at the three schools housed 175 students. The list of students waiting for placement was growing. The Committee on Building and Grounds of the board of education recommended the erection of a four room school for crippled children to accommodate not fewer than ninety pupils. It was specified that the construction was to be separate and apart from regularly established schools in the area of Ashland Avenue and Washington Street. This central school was in the proximity of the Home for Destitute Crippled Children, now being referred to as the "main institution for the surgical and medical care of cripples."

Having purchased the site for the construction of the school, the Committee on Buildings and Grounds authorized travel to Boston for Mr. Dwight H. Perkins, architect; Mrs. Keough, a committee member; and Mrs. Haskell, principal. This inspection trip was to gain ideas in regard to physical plants and educational programs to be incorporated into the new facility. In February 1906, the School Management Committee approved the construction of this central school with provision for additional branches as needed.[13]

The board appointed a Special Committee on Cooperation between the schools for crippled children and the Home for Destitute Crippled Children. It consisted of Mrs. Anita McCormick Blaine, Chairperson; Jane Addams; and P. Shelly O'Ryan. Following several conferences with Mr. Colin Fyffe, Vice President of the Home for Destitute Crippled Children, and other authorities of the home, several recommendations were made. The principal was to be responsible for the supervision of all staff, including an additional staff member to meet the physical needs of the children thus freeing the janitress for food preparation. Both women would serve the food and clean the area following the meal. Most of the cost of the food would be from donations, with the remaining amount to be provided by the board. The home would pay for the cost of the luncheon to their patients who would attend the school.

Secondly, it was recommended that all children from the home be admitted without extra examination to determine their fitness: a saving for the board of education. The new construction allowed for more of the hospitalized patients of the home to move into greater association with their peers. Finally, a kindergarten class was to be added prior to first grade in an attempt to prevent some of the retardation frequently found in physically involved children.

A request was made for the addition of one teacher to serve the children of the home who would be bedridden and unable to attend classes in the new school. This hospital bedside instruction would only take a portion of the teacher's day: the remainder of the time could be used for reinforcement instruction within the school.[14]

The home would agree to provide the services of its physicians to the students of the new school. The medical staff would give general inspections and directions in physical matters and make reports on such activities to the board. In addition, the school would receive daily services from a nurse. Each morning the nurse would dress the wounds of pupils who did not receive appropriate care in their own homes. All medical supplies and equipment were to be provided by the board of education.[15]

This cooperative effort was noted as being as complete as possible between the physical work for the children in the home and the educational work for the same children in the school. This initiated a continuing "harmony of work between the two institutions."[16]

The board recommended that the school be named the Jesse Spalding School in honor of the "well known, public spirited citizen." Spalding was a lumberman and became an important business leader in the Chicago area during and after the Civil War. His lumber business and his generosity was of great value in rebuilding the city after the fire of 1871. The school was also named for Spalding because of his liberal donations to the Home for Destitute Crippled Children.[17]

Opening the School

Superintendent Cooley was notified by the Committee on School Management that the Spalding School for Crippled Children would be ready for occupancy on 3 September 1907. He subsequently authorized the transfer of all equipment and supplies from the old building to the new facility.[18]

Special adaptive equipment was furnished at the new facility. Seats and desks were ordered to meet the needs of the handicapped population. Since some specific needs could not be met by purchasing commercially prepared items, the architect of the board requested that the repair department manufacture the portable tables and chairs required for the dining room. Ventilating equipment was installed in the attic to properly air the building.[19]

Special instructional equipment was made available to the staff and funds were allocated for the purchase of materials for construction work. A printing press, type cases, type stand, as well as supplementary materials for the print shop were made available.[20]

Spalding School Staff

The mandated requirements of special qualifications and special state certificates for teachers of crippled children in schools and hospitals created many staffing problems due to the lack of qualified teachers. Although repealed by the legislature in 1905, the board of education maintained the additional course requirements for assigned teachers until 1907. At that time, Mr. Kraspauph, newly appointed Spalding principal, requested that the rule be rescinded and that teachers be assigned to the rooms for crippled children in the regular manner. He reached this conclusion following visits with all qualified personnel whose names appeared upon the available list. Although many appeared to be energetic and hard-working, he was not able to find one who was "elastic, adaptable or skillful enough" to service this specific student population. In his view the maintenance of this rule by the board of education hindered the selection of the best teachers for the work. When the board did finally repeal the mandated course requirements they initiated a program of salary increases payable upon evidence of satisfactory completion of the courses in an effort to encourage professional growth of staff members.[21]

Student Eligibility Determination

Dr. John Ridlon, Chief Orthopedic Surgeon for the Home, with the assistance of Dr. W.S. Haspole of the medical staff of the board of education, furnished a report detailing the considerations required in the medical examination of students prior to admittance to the school for crippled children. The doctors suggested that the examination include, but not be limited to: the medical classification of pupils; information on pupils who would not be injured by riding on the bus; information on children who would be injured by riding on the bus; and information on those who might be sent to the normal schools. The report was to include any additional information that might be deemed appropriate to the investigation. Additional considerations were given to the ramifications of the child's diagnosis. This included the distance from the nearest school to which the children would have to walk, the number of flights of stairs it would be necessary to climb to classrooms, and the care and attention they would require in the ordinary classroom.[22]

Of the 130 students initially considered for admission and examined medically, 20 were excluded from school for their own good as well as the good of the others in class. Thirty-nine of the study group were considered transferable to other public schools without doing harm to themselves or others. Seventy-one were to be cared for apart from the general student population. These in addition to 18 who were brought daily from the hospital were the first students enrolled in the new school.

The students recommended by Dr. Ridlon for inclusion at the new facility included those with the following diseases and deformities: infantile paralysis; spastic paralysis;

amputations; facial deformities; congenital club hands; congenital short leg, congenital hip dislocation and hip deformity; and spinal deformity. Excluded from school were individuals with defective hearts and those suffering from epilepsy. Students identified as having contagious diseases were excluded from school until the immediate danger to others was removed. Despite the high degree of nursing care available, those with discharging tubercular sores were deemed to be a menace to others, and were excluded. Those with spastic conditions, that prohibited them from telling their name, address or age, were excluded as being mentally defective and unable to receive any benefit from the schooling. Some children, previously excluded were admitted as soon as they received the necessary equipment, such as crutches and spinal supports.[23]

Ultimately, however, each case considered for admittance to the school was reviewed individually. Interviews with both parents, the student, and school staff, provided information in addition to the medical examination and school history. Admittance to the schools for crippled children required an examination by the child study department staff as well as the regular medical inspector from the health department of the city. The medical staff was to determine if the child was a "bona fide cripple" and in need of free transportation to and from the school. The child study department was concerned with the mental status of the applicants. They determined whether the child was of a sufficiently "high grade of mentality" to profit by class or individual instruction in these special schools. The physical conditions of many children were felt to give rise to many forms of mental abnormalities which resulted in some children being excluded from the program.[24]

The decision to exclude a child could be reviewed at the request of the parents. The case of David R. illustrates the review and appeal process which was in place for application to the programs for crippled children. David was examined by medical staff and found to be afflicted with infantile paralysis and to be practically helpless. He was not recommended for admission to the school. He was found to be of a mentality which the public schools could not educate. The parents petitioned to have the matter reconsidered. David was again examined by board of education personnel. At this examination it was determined that he was a questionable case. Provision for cases in which there was an area of doubt was made under Board of Education Rules (Section 392). This allowed for a three month trial period. At the end of the trial period, another review was held for David R. and he was excluded.

The case of William H. presents another illustration of the examination process. At age twelve and nine months, William was examined by Dr. Harpole, a physician from the Child Study Bureau. William was found to have mitral and tricuspid valve defects, in all probability a congenital cardiac problem. Records indicated that he had never ridden to school, had always walked, and did not have any problems of ambulation. Drs. Dwyer and Harmison recommended that William be provided bus service because of his organic heart disease which was of a severity sufficient to make it dangerous to walk any distance. The child study department did not concur in the recommendation. They were of the opinion that for his own good he should not be in any school and that the parents, and not the teacher, should incur the danger of the possibility of his passing away at any time.

William's case is indicative of the inconsistencies to be found within the review process. Here an attending child was removed from the regular school program. The records did not indicate an appeal.

A child described as "pale and slightly anaemic" was allowed to enroll. Admittance was based upon the fact that the father was unemployed and the mother was "slovenly and careless." Because of the poor home conditions and the fact that the child walked with considerable difficulty, she was admitted to the school for crippled children.

In another case, a child was felt to be neglected at home, and it was believed that it was to the child's physical benefit to receive care at the special school. The child had a wound that would not heal and the mother did not care for the wound properly. The Visiting Nurses' Society came to change the dressing applied to the child's wound in hopes that with proper care, the wound would heal and not pose a potential danger to other children in the class.

In other cases, the medical staff, in consultation with educational staff, reviewed the individual accommodations made at the local school and recommended the maintenance of the student in that regular school setting with normal children. Here the child could "enjoy the wholesome influence of association with normal children."[25]

Enrollment in the classes for the crippled varied because children were returned to regular grades as soon as they were able. When children had sufficiently regained their strength following illness or accident, they were transferred back to their local schools.[26]

Instructional Program

John Dewey and his experiential philosophy had a strong influence upon the schools at this time. His colleague, Ella Flagg Young, General Superintendent of Schools, directed that education meet student needs. The school was seen as a means of developing the child's skills for social, as well as personal, benefit. Children were to be taught how to deal with a constantly changing world.[27]

During this time, the educational program for pupils of the crippled children's schools was based upon the regular course of study which included reading, arithmetic, language and history as well as training in manual and household arts. This included sewing, crocheting, darning, fancy needlework, basket making and other construction work. The goal of industrial training was to make the "cripples independent and helpful to others.[28]

The course of study at both special schools and hospitals was modified and adapted to physical needs and abilities as well as consideration given to the anticipated length of stay at the institution. Some pupils were there temporarily to return to their regular schools as soon as surgical treatment would restore their normal functioning. Special emphasis was placed upon construction work with modifications appropriate to individual needs to prepare students for employment.[29]

Monthly meetings were held for parents by the staff of the Home for Destitute Crippled Children. These meetings were aimed at eliminating some of the skepticism that prevented many parents from allowing their children to be treated by the modern medical programs of both the hospital and school. As a result of these sessions, many children received the treatment regimens that they needed.[30]

Through the efforts of The Outing and Luncheon Association of the School for Crippled Children, the daily excursions were extended to include visits to the country. Their aim was to "elevate ideals and promote self-respect" essential in building a "well balanced character." Intended for recreation and nature study, the country outings were new experiences for children so limited physically and socially.[31]

There were outings to Crystal Lake, Illinois, and Brown's Lake in Burlington, Wisconsin. The facility at Brown's Lake, originally known as the Crippled Children's Camp, was started by Mrs. Emma Haskell. (She and her sister, Mrs. Bonheim, formed the Outing Association for Crippled Children.) There was no charge for attending the camp. The camp provided the patients with large quantities of fresh air, wholesome food, and good care. All staff was voluntary. The physical supervisors insured that the hospital treatment was carried out. Special adaptive equipment was available. The children returned to the city ready to meet the new treatments, and their school experience became a "Door of Hope" to the future.[32]

Expanded Medical Services

The initiation of new medical services had implications and ramifications for future regular and special education students. As it was with the study of the causes of truancy; so it was with the study of the medical needs of students. In June 1908, the Commissioner of Health, Dr. W. A. Evans conferred with Dr. Herman Spalding, Chief Medical Inspector of the board of education. The prevailing practice was to examine students for communicable diseases only. Service was expanded to include examinations of all pupils and to look for diseases which might "retard the progress and development of the child." It was suggested that they be especially aware of diseases which "shorten and destroy life."

When such problems were discovered, parents were to be advised of the need for medical and/or surgical intervention. These conditions included but were not limited to; nutrition, chorea, enlarged glands, and heart, skin and pulmonary diseases. This recommendation was an effort to enlarge the scope of the present school medical inspection and thus to increase benefits to the students of the city. The proposal requested the use of a room within the school for examinations. All medical inspectors visited their assigned schools daily. No further cost was incurred unless nurses were assigned to follow up on the results of the medical examinations to see if the recommendations were acted upon. The suggestions were accepted as outlined by Dr. Evans, and the board of education joined in this cooperative venture with the Health Department.

Of the first 110,002 children examined, 6 percent were found to be undernourished, 10 percent had post nasal growths, 18 percent had enlarged tonsils, 31 percent had defective vision, and 25 percent needed dental care. Medical or surgical care was needed by 2 to 3 percent of the group. Parents of 81 children gave their permission for surgery . Six months later, 76 had been re-examined and all found to be doing well enough to be promoted to a higher grade.

The medical inspectors did not treat cases, but recorded their findings in the school chart of the child. It was suggested that nurses be available to follow up by visiting homes and to see that treatment was begun. All children afflicted with non-contagious diseases remained in school during the course of their treatment.[33]

Summary

In the early days of the special education movement, medicine and education overlapped, with each at times venturing into the domain of the other. Both were under the constant pressure of reformers and special interest groups to improve the lives of children. These societal forces resulted in the development of needed services which were provided by both medical and educational practitioners. The result was the improvement of services to crippled children by the Chicago Public Schools. This was followed by legislation which allowed other Illinois districts to follow suit. Special programs expanded and were adapted by educators as innovative expressions of an awakening public interest in the welfare of children with debilitating health conditions.

In the following chapter, we will see the effects that the epidemics had upon the educational services provided in schools, hospitals and homes. As the numbers of eligible students grew, experimental programs became accepted practice.

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CHAPTER 3

EXPERIMENTAL PROGRAMS BECOME STANDARDIZED

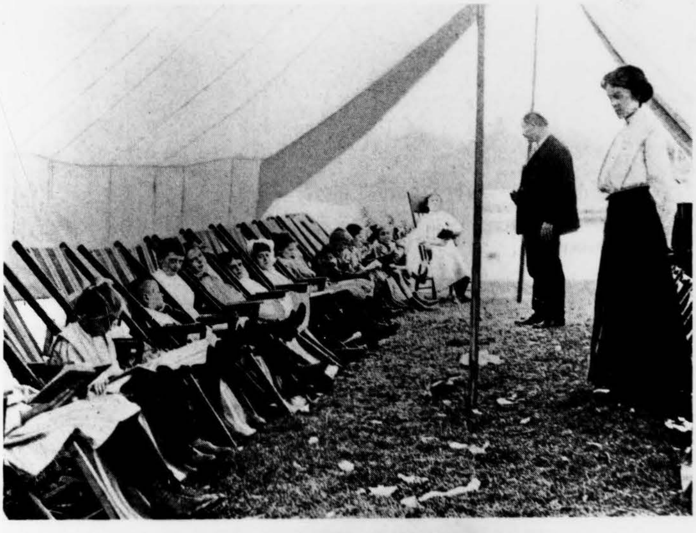
Introduction

Tuberculosis became a world wide problem in the early twentieth century. One of the early efforts at controlling the disease in this country was an "open-air recovery school" modeled after one initiated in Charlotteburg Germany in 1904. The sessions were held almost entirely outside. Children received a modified academic program, appropriate clothing, and good food prepared and served in sanitary conditions. Most students showed impressive physical gains and many students were cured. Both of these accomplishments were usually accompanied by increased academic progress. Other cities in Germany started similar programs. In 1907, London opened its first open-air school and reported comparable results. Providence, Rhode Island established the first American open-air school in 1908.[1]

It was estimated that nationally from 2 to 10 percent of school aged children were so physically deficient that they were unable to make normal academic progress. Leonard Ayres, Associate Director of the Department of Child Hygiene of the Russell Sage Foundation, estimated that the number of children needing the treatment of the open-air classrooms was between 3 to 5 percent, with one third of them being tubercular or pre-tubercular. In Hygiene of the School Child, Lewis Terman of Stanford University noted that school examinations had been "too superficial" to identify any but the most severe physical problems. He estimated that 15 to 20 percent of all school children were predisposed to tuberculosis nationwide. He indicated that 60 percent of the pupils had physical defects serious enough to interfere with school work and required the attention of a physician. He added his voice to those calling for more complete and thorough medical inspections of students. Educators believed that the presence of these children in class would serve as a detriment to the progress of normal students.[2]

In 1921, Dr. T. D. Woods, professor of education, Teachers College, Columbia University, stated in his report to the Committee on Health Problems in Education, "The world war revealed to this country no greater weaknesses than the neglect of education and the neglect of health." Dr. Woods argued that funds spent on preventative or therapeutic measures would reap great benefits to the child and society as a whole. Although twenty-one states enacted legislation mandating physical education since 1915, he estimated that 75 percent of school children nationwide had physical defects which were potentially or actually detrimental to health, yet remediable. Therapeutic school programs were designed to help return children to "normal mental and physical vigor." Education was secondary to health needs in these programs.[3]

The classroom tent of the first Chicago school



Tent interior, Chicago

Photograph One: The first Chicago open-air classroom tent.

Source: Leonard P. Ayres, Open-Air Schools, (Garden City: Doubleday, Page & Co., 1911) 28.

Photograph of the Chicago roof tent, as published by *The Survey*, to illustrate permanent construction

Photograph Two: Eskimo suits in the open-air school room.

Source: Leonard P. Ayres, Open-Air Schools, (Garden City: Doubleday, Page & Co., 1911), 35.

The growth of the medical profession and its allied facilities provided increased resources for the treatment of handicapped and diseased children. Philanthropic groups spurred by progressivism, moved boards of education to establish new programs to meet the needs of special students. This chapter will document the effect of these forces in creating experimental programs which became standard features of the Chicago Public Schools and on the instruction programs provided in open-air programs, hospitals, convalescent homes and camps.[4]

Chicago Open-Air Programs

The public's recognition of the need for institutional treatment of tuberculosis in Illinois resulted in the passage of the City Tuberculosis Sanitarium Act in 1909. It provided not only an institution for the care of patients, but included dispensaries, field tuberculosis workers, educational activities and disease control measures in cooperation with institutions, sanataria and hospitals. A site was purchased and plans developed for the construction of the Municipal Tuberculosis Sanatarium (MTS). The facility, whose design and plan were based upon data from surveys, treated between 1,500 and 2,000 patients annually.

Tuberculosis dispensaries which had been operating with volunteer workers from the Chicago Tuberculosis Institute

(CTI) since 1907, were taken over by MTS in 1910. Despite all efforts, the number of reported cases of tuberculosis in the City of Chicago increased.[5]

Table 1.--Reported cases of tuberculosis in Chicago

Year	Number of Cases
1906	277
1907	919
1908	2,577
1909	4,089
1910	6,121
1915	12,709

Source: City of Chicago: Annual Report of the City of Chicago Municipal Tuberculosis Sanitarium, (Chicago: n.p., 1916), 12.

In 1916, Dr. Theodore Sachs, Dr. John Ritter, Mr. James Minnick of the CTI, Dr. James Britton of the MTS, and Mr. Sherman Kingsley of the McCormick Memorial Fund initiated a series of lectures for physicians, nurses, social workers, and teachers interested in fighting this disease. The CTI funded the project which resulted in a printed series called the Bulletin of the Chicago Tuberculosis Institute. It was distributed free of charge upon request.[6] The CTI also engaged in educational work within the public school system. They distributed flyers detailing facts regarding the spread of tuberculosis and the means of avoiding contamination. (See Appendix A.) The intent was also to educate school staff on the importance of providing fresh air in educational settings to improve student's health. Dr. Sachs, called for a change in the conception of community responsibility to children so that healthy growth rather than unhealthy development would be encouraged. He called for pure air in school rooms, a medical inspection service, adjusted study hours, and a curriculum adapted to the needs of the growing child.[7]

At the same time, philanthropic work began to address the needs of children predisposed to tuberculosis. These efforts developed into a movement which was to initiate the first Chicago open-air experimental school operated cooperatively between the public schools and the CTI. During August 1909 the class met in a tent erected on the grounds of the Harvard School. The goal was to demonstrate what fresh air and proper food would do for children predisposed to tuberculosis. The CTI provided the food and its preparation, carfare, and nursing care. Their medical staff identified children to be included in the program.[8]

The first group of thirty children were described as being "limp, pallid, physically blighted children." In school they were "listless, inattentive, uninterested and uninteresting." At the end of a month of proper food, rest and exercise an increase in alertness and improved ability to benefit from instruction was noted.

Although called a "school," the program was mainly devoted to health improvement activities. Balanced meals were followed with information on proper diet and cleanliness.

Classes in domestic science and deep breathing were provided and proper dental hygiene was taught and practiced. Baths or showers were followed by lunch and extended rest periods. Medical charts were maintained indicating the patients' progress. Weight and temperature were recorded daily. Discharge orders were written for those able to return to the regular school program in September.[9]

The results were so encouraging that Superintendent Ella Flagg Young recommended continuation of the program. She entered into a venture with the Elizabeth McCormick Memorial Fund to establish another open-air class on the roof of the Mary Crane Nursery, next door to Hull House. A grant managed by Sherman Kingsley, Superintendent of the United Charities for the McCormick Fund, paid for fencing the roof and the construction of an asbestos board room to provide shelter from extreme cold, precipitation, and strong winds. The room was designed so that the sides could be completely open in good weather. Sufficient room remained on the roof to allow children to take their rest periods outside when weather permitted. The fund supplied food, nursing services and proper clothing for the children. Students were given woolen underwear and outer garments. Each child had a "heavy overcoat, a sitting-out bag, two blankets, a knitted toboggan cap, and warm gloves." Called "Eskimo suits," these garments were considered satisfactory by program administrators and staff. Each teacher was provided a warm coat, cap, mittens, and felt shoes. Heated foot boxes were available for both students and teachers when the temperature dropped.

Twenty-five students received treatment six days a week. They were so enthusiastic that they asked to continue during Christmas vacation. Their request was granted and the program was added to the vacation school schedule as well. Of such priority was this experiment that at the June 1910 meeting of the board of education, the schedule was extended for a week beyond that of the other programs. When records were reviewed at the end of the year, administrators decided to continue the program during the 1910-1911 school year with additional rooms to offer the same treatment to more children.[10]

A similar program was the open-window room. Where possible, local schools selected corner rooms with southeast or southwest exposures so that frail, children who could not endure the strain of long rides to reach the open-air schools, would benefit from the sunshine and outdoor environment. A temperature of fifty to fifty-five degrees was maintained through the winter.[11]

The climate of the classroom was controlled. The windows were kept open so the volume and temperature of the air changed with the season, although steps were taken to prevent the wind from blowing directly upon the children by means of window swings or hinged windows which opened inward. Some divisions were housed on the roofs in open tent-like structures. The specific sites were chosen to provide air uncontaminated with dust, smoke and chemicals. However, these divisions were criticized for isolating the children unnecessarily from the activities and advantages of the regular schools.[12]

During the school year 1911-12, there were four open-air and eight low temperature (open-window) rooms providing services to 246 children. The classes were held to a maximum of twenty-five pupils with a range of from two to seven grade levels. The health of children was of prime importance; academic work became secondary. Teachers scheduled lessons around the work of the doctors and nurses.[13]

Vacation classes for children with anemia and/or low vitality were conducted completely out-of-doors. The sites were located near parks or playgrounds so children could benefit from the grass, trees, shrubbery and flowers, as well as the fresh air and sunshine. All contributed to the general improvement of the physical condition of the children.[14]

The McCormick Fund, the School Extension Committee of the Woman's Club, the Health Department and the CTI were all providing funds or services to these classes. Medical work was supervised by the attending physicians, the health commissioner, and tuberculosis workers. In 1911, at the request of the board of education, the fund assumed responsibility for all school programs and began standardization of operational methods. In 1913, MTS assumed the provision of all medical and nursing services to the open-air programs. By this time, there were twenty-one rooms, located in thirteen schools with an enrollment of over 650 students.[15]

The program developed by the McCormick Fund and MTS considered the following seven items essential:

> 1. a thorough understanding of the child, both physically and mentally; the school should provide opportunity and facilities for adequate medical and nursing service.
>
> 2. Food: The anemic and under-nourished condition of physically subnormal children is often due to insufficient or improper food. The open air school undertakes to meet this need by furnishing food in sufficient quantity and variety and wholesomely cooked.
>
> 3. Rest: Many of the children are suffering from conditions which call for an unusual amount of rest . . . . Open air schools generally have adopted the plan of giving all the children a period of an hour or more rest each day.
>
> 4. Personal hygiene: Cleaning and care of teeth, bathing, regular habits of cleanliness, regularity of meals, the acquiring of a taste for proper kinds of food and the right habits of eating are emphasized.
>
> 5. Fresh air and sunshine: The open air school aims to give the child the advantage and mental stimulus afforded by adequate fresh air and sunshine.
>
> 6. Curricula: The work in the open air school is generally characterized by freedom and elasticity; manual training, gardening, and handwork of different kinds, nature study, outdoor exercise.
>
> 7. Individualization: Open air schools for anemic and undernourished children aim to give a smaller number of children to each teacher; from twenty to thirty has been agreed upon as the maximum for a class.[16]

Students assigned to these divisions were selected by the nurses and physicians of the board of health. A few were recommended by the principal and school staff for examination by the Department of Child Study and Educational Research. Preference was given to those with low vitality, tubercular tendencies, and a family history of disease. Pupils from homes unable to provide the proper quality or quantity of food, or who received insufficient care, were also admitted. The divisions were located in schools where large immigrant populations were most in need.[17]

The program was planned to develop the "natural recuperative" ability of the body. Food was prepared and served in the school building as often as three times daily. Each child was given milk in the morning, a lunch of soup, bread, milk and vegetables, and another cup of milk in the afternoon. Cots and blankets were provided in the low temperature rooms so the students could rest for an hour after lunch.

The teaching staff received regular salary for working in the divisions, and were made aware that the main purpose of the class was to improve the physical condition of the students. However, the students were not regarded a being "backward" but proceeded with the usual school work despite the low temperature. Daily physical examinations given to all children. Temperature and weight were recorded. Weight gains were the major physical changes noted.[18]

Hospital Programs

In the early part of the twentieth century, hospital stays varied greatly in length from a day or two to several years. Often, children were unable to be cared for at home, and were not well enough to attend the special school health programs. They were maintained at the hospital until cured; especially if the family did not have the means to utilize one of the private convalescent homes. To meet the educational needs of these children, the Rotary Club and other organizations encouraged the development of hospital school programs. Some of the more prominent programs are described in the following sections.[19]

In 1915 volunteer teachers from the Chicago public schools began providing instruction to patients at Cook County Hospital after school hours. Each teacher gave an hour a week to teach children in the orthopedic ward. After a period of about six months, the hospital administration acknowledged the need for a permanent program and requested the board of education to provide a full time instructor for the confined children. The Social Service Director stated that "a bedside teacher would bring the knowledge they [the children] need besides being one more aid toward establishing health by keeping mind and hands busy." In January 1916, a teacher from the Marquette School was assigned as a hospital instructor. In 1918, the hospital made a classroom available so that some children would have the benefit of group contact and instruction.[20]

Two hours of individualized instruction was offered daily in a class for students who ranged in grade from one to eight. A branch of the Chicago Public Library, housed on the eighth floor, provided many supplementary materials from which the teacher could draw. During the summer session of six weeks, class was often held on the roof or in the bandstand in the yard. This offered the opportunity for program innovations such as the creation of a drum and tambourine band.

Table 2.--Cook County hospital school enrollment, 1925-6

Grade	Number of Pupils
1	40
2	21
3	25
4	19
5	33
6	26
7	18

Source: Cook County Hospital, <u>Annual Report for the Fiscal Year 1916</u>, (Chicago: Cook County Hospital, 1916), 23.

Occupational training was provided for older students in a program jointly operated by school and hospital personnel. Handwork was an important part of the curriculum at the hospital school. Sewing and light woodwork provided manual training. Basketry, bookbinding and clay modeling were also taught with adaptations to the individual preference and physical condition of the child. Two hours weekly were spent on craft work. Older girls received lessons in dressmaking.

During the sewing lessons, hints on proper work attire were provided as well.[21]

The Municipal Tuberculosis Sanitarium instructional program began as a branch of the Mayfair School in January 1916. The sanatarium provided three open-air school rooms in the cottages on the grounds.[22] Children over the age of five attended school from three to five hours daily. Academic work was provided for grades kindergarten through eight with an enrollment of over three hundred students in January 1918. The program included manual training, nature study, and gardening. Each child was assigned a plot of ground where he planted and cared for his own garden. A half day summer school was offered during July and August.[23]

The MTS preventorium was opened in 1918 to treat those who might develop tuberculosis. Records indicated that 2,300 children were treated during the first year of operation. The length of stay varied from a few days to a year. To educate these students, eight teachers each served thirty students. Staff reported that students progressed at a normal rate in classrooms where windows were always kept open and pupils wore coats and caps. Outdoor activities were provided both winter and summer.[24]

In 1920 the board hired another teacher to advise the staff in industrial subjects. The vocational division expanded to offer a full set of courses including: dressmaking, commercial art, telegraphy, typewriting, stenography, barbering, sewing, beauty culture, cobbling, carpentry, pharmacy, and laboratory work. A teacher offered amusement and cultural development through a program of music and recreation. An orchestra was a feature of this department. Instruction in citizenship and industrial education were offered as well.[25]

By 1922 there were nine teachers for children and seven, including a head teacher, doing shop and craft work with adults. The sanitarium had become so crowded that the board had to provide six portable school buildings for the children's classes. Shop work was carried on in basement rooms of the laboratory and infirmary. Four additional teachers were assigned to teach boys and girls in the preventorium.[26]

In 1921, the Director of the Illinois Eye and Ear Infirmary requested and received the services of a teacher for twenty to thirty children hospitalized for defective eyesight, mastoid infections, or from diseases or accidents to their eyes. Each had a half hour period of individual instruction followed by arithmetic, geography, spelling, storytime, and crafts. Special books with large print were used to assist the visually impaired students.[27]

Acting upon a request from the Board of Trustees of Children's Memorial Hospital, in 1923, a teacher from the Lincoln School was assigned to instruct the twenty to thirty convalescing patients. By 1930 three teachers were providing bedside or small group instruction in academic subjects and hand work to children handicapped by orthopedic and cardiac problems. By 1940, five teachers provided service to almost five hundred students whose length of hospitalization ranged from three days to one year.[28]

In 1924 teachers were assigned to Lawndale Hospital for adult instruction. Seventy to eighty women confined for treatment of venereal diseases were offered both academic and industrial instruction. The Municipal Contagious Disease Hospital was provided teachers at the same time. This twelve month instructional program served between fifty and seventy-five girls, ages seventeen to twenty-seven, hospitalized for the treatment of venereal disease. The two assigned teachers gave instruction in citizenship and industrial arts.[29]

The first teacher was assigned to Shriners Hospital in 1926 as a branch of the Lovett School. Most of the children were hospitalized for orthopedic surgery. A series of casts and physiotherapy followed surgery, made recovery periods very long. All academic work was done at bedside due to the conditions of the patients. The Lovett School adjustment teacher provided instructional materials based upon Kuhlmann-Anderson and Stanford Reading Test scores. Occupational therapy, through weaving, woodwork, basket-making and art work not only provided vocational training but was important in the healing process.[30]

The hospital instructional program continued to expand with teachers assigned to LaRabida, St. Lukes, and Billings Hospitals. During the school year 1939-40, five hundred patients a month were provided with an educational program. The annual report of that year noted three principle purposes attached to the hospital school programs: to continue general educational development; to have therapeutic value; and to be of some vocational assistance.[31]

Teachers requested and received a record of school progress from the home school. This included grade placement, subjects to be studied, textual materials, and information regarding special abilities and needs. When leaving the program, a record of work accomplished was returned to the home school. The related services of speech, occupational therapy, and counseling were offered through cooperative efforts of private and public providers.

In 1939 new hospital schools were established at Michael Reese Hospital and Illinois Research Hospital. A third teacher was assigned to LaRabida Sanitarium. Nine of the established programs provided psychological, psychiatric, sociological, and special education support. The most common types of disabilities found among hospitalized students were poliomyelitis, osteomyelitis, bone tuberculosis, spastic paralysis, scoliosis, arthritis and cardiac conditions. The largest number of children suffered from orthopedic and cardiac problems.[32]

Convalescent Homes and Camps

A survey of crippled children done in 1924, indicated that many were waiting for hospitalization due to the limited bed space in existing facilities. This spurred the development of additional camps and homes which provided medical care and support for those who were not sick enough to be hospitalized but were not well enough to function normally. It was felt that without intervention these children would succumb to acute illness, become invalids and drain societal resources. Instructional programs were established in these homes and camps as well. Some of the more prominent facilities are described in the following section.[33]

The Francis Juvenile Home provided medical care for girls from one to fourteen years of age who were suffering from hereditary social diseases. The board of education constructed a portable school building and teachers were assigned from the Burke School. The academic work was individually adapted to the weakened condition of the girls. Records indicate that the average number of students enrolled was from eighteen to twenty.[34]

The Chicago Home For Convalescent Women and Children provided a temporary shelter for those between the ages of four and twenty-five who had been discharged from hospital wards before they were well enough to return to the often unfavorable conditions of their homes. Established during the 1919 school year, the academic program provided at the home was expanded to twelve months during the first year of operation. An important feature of the program was the quarterly publication of a newspaper, <u>The Chicago Home Courier</u>. Student stories, poems, and drawings provided news regarding life in the home. Approximately 120 girls were enrolled during the 1940-41 school year with the average length of stay from three months to one year.[35]

United Charities funded Camp Algonquin in 1914. Originally, the camp was to offer families a special summer outing. It developed, however, into a program for patients who had been treated at MTS. Over two hundred boys and girls, from the poorer districts of the city, came to improve their health by receiving good food, fresh air, exercise, rest, and recreation. By the summer of 1929, courses in sewing, handwork, nature study and manual training were offered.[36]

Sunset Camp, organized in 1915 to provide summer outings to underprivileged children, was located in Antioch, Illinois. By 1923, the program began to accept children with heart disease under the supervision and direction of the Chicago Heart Association. A resident doctor and three nurses monitored a daily routine designed to improve the cardiac condition of the children. The program was started as an experiment, but became accepted by physicians as a "definite phase" of cardiac convalescence. Teachers were assigned so that the children would not be delayed in their academics if and when they were able to return to school.[37]

In cooperation with the Arden Shore Association, money from the Elizabeth McCormick Memorial Fund, and the support of Mrs. Ira Couch Wood, a winter camp for 125 undernourished boys was initiated at Lake Bluff in 1919. Students between the ages of fourteen and seventeen were selected from those denied work permits by physicians of the board.[38] The schools salaried two teachers twenty-four hours a day, seven days a week while the association provided house attendants, a nurse, a recreational director and all food and clothing. The length of stay was from three to six months.

A similar facility, Ridge Farm Preventorium, was operated for girls in need of physical care and monitoring to prevent the development of tuberculosis. Healthy living was taught by requiring them to live in a healthful manner. The girls were directly involved in the preparation of meals and maintenance of the camp. Academics consisted of two hours of ungraded instruction daily.

The Forward Movement Camp at Saugatuck, Michigan opened in 1920. Children who had been privately employed, but whose health had deteriorated during their work experience were accommodated. Examiners of the Employment Certificate Department referred cases to Dr. Frank Bruner, director of the special nutritional centers, for approval. Rest, nourishment, and training to redirect them to an occupation appropriate for their physical and educational status were provided in stays of from one to four months.[39]

As the private funding for these special health programs began to decline they were generally discontinued. Some of the board of education instructional camp programs continue to this date but their focus has changed and are currently programs of nature study.

Administrative Considerations

George D. Strayer, in 1932, following an intensive study of the Chicago schools recommended the assignment of specialists responsible for city-wide divisions of the schools. Assistant superintendents were to be assigned to elementary education, secondary and higher education, special schools and special classes, personnel, and business affairs. District superintendents were to be assigned for each of the categories. Provision was made for both line and staff officers to serve different functions. Line personnel would be responsible for administrative aspects; staff would provide support service to the schools by coordinating services within the system and the existing classrooms. Staff would also aid in the improvement of instruction. They would provide information on new techniques and methods of instruction, the educational environment, new equipment and textual materials, and the content of the instructional program.[40]

For administrative purposes, the Bureau of Child Study, the Bureau of Compulsory Education, and all special schools and classes were grouped as a unit. During the school year

1939-40, system-wide supervision of hospital schools was implemented for the first time. Considerable progress was noted in the improvement of instruction to confined students through visits, observations, and conferences. Reports asserted that the supervisory service of staff coordinators improved the coordination of instruction.[41]

The belief that the public schools had responsibility for the education of all handicapped children was evolving. By 1940 administrative and financial considerations slowly shifted from outside agencies and private funding sources to the public schools. By the end of the regular session of the Sixty-second Illinois General Assembly, 30 June 1941, a number of laws relating to the operation of educational programs for the handicapped had been enacted. In doing so, state representatives acknowledged responsibility for the education of these children. The session passed enabling legislation and appropriations to local school districts for the excess costs of establishing and maintaining special schools and classes for the education of crippled, deaf, hard of hearing, blind, visually defective, delinquent, truant and incorrigible children.[42]

The Department of Public Welfare was charged with the responsibility of authorizing payment of claims upon approval of the Superintendent of Public Instruction for special schools and classes established under these laws.[43] With this legislative basis, Chicago continued to operate programs for crippled children, including programs for students who were hospitalized. The legislation defined crippled children as "any child between the ages of five and twenty one years (section 123) who is deformed in body or limb, and who cannot profitably or safely be educated in the regular classes." Children, certified by a physician to be mentally or physically unfit to attend school were excused from attendance.[44]

In December 1947, a revised administrative configuration was approved by the board of education. This structure defined three administrative positions; line, staff, and service. The line organization consisted of those positions in a direct line of authority from the general superintendent of schools to the classroom teachers. Staff positions were those filled by experts and specialists in a given field who had little or no line authority. Their functions were advisory; providing information and advice to assist line officers. The service positions were filled with experts and specialists such as the comptroller, the chief engineer and the architect.[45]

Under the new plan, Dr. Harold Hunt, general superintendent, recommended the appointment of Mary E. Courtenay as Assistant Superintendent in charge of Special Education. Reporting directly to her were the directors of the bureaus of exceptional children, special classes, child study, guidance and counseling, and school attendance. The bureau of exceptional children was soon renamed and became the bureau of services to physically handicapped children. This director was responsible for supervision of deaf-oral, sight-saving, braille, orthopedically and other physically handicapped divisions. The functions of the bureau were as follows:

1) to collect statistics.
2) to supervise and coordinate staff.
3) to assess curriculum needs.
4) to develop instructional techniques.
5) to cooperate with community agencies.
6) to place students.
7) to obtain appropriate student equipment.
8) to request needed physical adaptations.
9) to ensure compliance with state mandates.
10) to prepare and submit reimbursement requests.[46]

With the administrative reorganization and role redefinition, a more precise structure was intended; in reality each of the bureaus continued to supervise and work with teachers and students in categories other than their stated function. For example, the bureau of mentally handicapped supervised the divisions of ungraded children and the division of speech correction. The responsibilities of the bureau of child study included services of child study, psychiatric clinic services, program supervision and instructional technique development. It did not however, provide for instruction to students hospitalized for psychiatric reasons. By default, that function was taken on by the bureau of physically handicapped. Their services were extended to provide for students hospitalized in the newly developing psychiatric units.[47]

Summary

Medical facilities multiplied and techniques improved as doctors tried to slow the epidemics of tuberculosis and influenza. The problems illuminated by World War I also led the schools to establish programs and provide more and more services for the handicapped. Progressive educators moved from traditional to experimental classrooms to address the problems. The experimental programs became standard features of the schools. Hospital teaching programs increased. Teachers were assigned to convalescent homes and camps.

Special education had become an accepted and integral part of the Chicago Public School system with its own assistant superintendent, directors over specialized bureaus, and a host of coordinators and field personnel working directly with principals and teachers. The creative and often voluntary energy that had spurred the movement and fostered financial and legislative support, was replaced by a bureaucracy created by that legislation.

Yet it was not enough. As early as 1920, there was a request for teaching services to students confined within their own homes, but it was not until the polio epidemic in the late 1940s that the call for these services was heard and a home teaching program implemented. The next chapter will review homebound instruction in the city and will note further hospital program changes.

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CHAPTER 4

EXPANDING PROGRAM SERVICES

Introduction

Although special programs had been in operation for years many students remained out of school unserved, but not unnoticed. As early as 1920, the position of Social Service and Visiting Teacher was created to assist crippled children. Miss Florence E. Prouty, an experienced teacher, was assigned to investigate new cases. She identified students who were unable to travel but were not currently hospitalized for active treatment and those children who were "not recommended for admission." She made the following observations:

> There is a great, an intensely appealing need in the educational system of Chicago for specially appointed teachers to visit the homes of children who are so handicapped that it is impossible to transport them to the schools, and to give instruction to them for an hour, two or three times a week.

Miss Prouty's suggestion was not acted upon until 1947 when an epidemic of infantile paralysis kept large numbers of students at home for long periods of convalescence.[1]

This chapter will note the growing interest in handicapped children and review the extension of services under the Home and Hospital Program. It will also include a discussion of home instruction, increased services in hospitals and psychiatric facilities, and the development of a program to educate chronically ill students. The discussion will be followed by a summary of unsolved problems.

Growing Interest In Handicapped Children

At the 1939 White House Conference on Child Health and Protection, a major policy statement was issued in the form of "A Bill of Rights for the Handicapped Child." Among these were the right to "an education so adapted to his handicap that he can be economically independent and have the chance for the fullest life of which he is capable; [and] be brought up and educated by those who understand the nature and the burden he has to bear and who consider it a privilege to help him bear it."[2]

By the end of the regular session of the Sixty-second Illinois General Assembly in June 1941, a number of laws relating to the operation of educational programs for handicapped children had been enacted. This included compulsory attendance mandated for children between the ages of seven and sixteen with the following exceptions: children certified by a physician to be mentally or physically unfit to attend school were still excused from attendance.[3]

In 1942, the first Governor's Conference on Exceptional Children was convened. Governor Dwight H. Green stated that its purpose was to "further public understanding of the problems of these children, the resources and facilities available to meet the problems, and the needs of such children which remain unmet." A list of priorities indicated needed legislation and their recommendations and decisions were returned to the Illinois Commission for Handicapped Children for follow up. A Citizen's Committee on Legislation was formed. They recommended that "exceptional children . . . need an education . . . calculated to fit them for the kind of life which they shall be able to live . . . ."[4]

The Sixty-fifth General Assembly expanded the definition of handicapped children to include not only the orthopedically impaired, but all handicapped youngsters. Also included was an expanded definition of the socially maladjusted child. Services now were provided for children to prevent them from becoming truant, incorrigible, or delinquent.[5]

Implementation of the legislative program was hampered by the lack of qualified teachers. In September 1943, a division of special education at Normal University (Illinois State University) was created. Curricula were developed in the teaching of the mentally retarded, socially maladjusted, gifted, and physically handicapped. After a year of intensive study and writing, a formal instructional program began in the summer of 1944. A Master of Science in Special Education degree was added in 1945.

Despite the efforts of Normal University the number of special teachers available could not meet the demand. Pressure from medical, social and welfare agencies, including hospital schools and institutions, were brought to bear on the

State Department of Public Instruction to expand the program of special education for teachers. The state responded with additional funds. Expanded program options were available as early as 1948, but special education staff shortages continued.

Home Instruction

In 1947 homebound instruction was added to the hospital service provided for handicapped students. An increasing number of requests for these services began to come from parents, teachers, social workers, and medical staff. A trial home teaching program was initiated. The program followed the suggestions of Dr. Emil Hauser, an orthopedic specialist of Wesley Memorial Hospital. He requested that the hospital teacher be allowed to instruct discharged students at home until they were able to return to school. Soon the Wesley Memorial Hospital teacher began to spend half of her work day in this pilot project.[6]

So successful was the program that in September 1948, home instruction was made a regular feature of the Chicago schools. Three teachers were trained in techniques of individualized instruction by the division of child study. Since the largest number of students were on the south side of the city, two divisions were opened at the Christopher School. One home teaching division was opened on the north side at the Jahn School. The majority of the children served during the first year suffered from disabling orthopedic conditions or severe cardiac deficiencies due to rheumatic fever. Records and statistics were maintained for state reimbursement under programs for the physically handicapped.[7]

The school code provided enrollment in the orthopedic schools for "children of sound mind . . . who suffer from any physical disability making it impractical or impossible for them to benefit from or participate in the normal classroom program." These children were eligible for home services based upon a doctor's written recommendation. The medical statement had to specify why the child could not attend either a regular or special school. Instructional periods and assignments corresponded to the doctor's recommendations about the amount of time students could spend in study.[8]

By 1954, twelve teachers were working with children in homes. To identify the needs of confined students, a survey was taken on 10 October. There were 108 boys and girls in grades one through twelve receiving home instruction with an age range of from six to twenty. Of these, 86 came from regular schools, 17 from special schools for physically handicapped, and 5 were enrolled for the first time anywhere. Of the students 22 had been on home instruction for more than one year with a few for as long as five years. Students with cerebral palsy were the largest special school population but these children were not served at home. The medical diagnoses for the homebound students were as follows:

Poliomyelitis	26
Accident	18
Cardiac	16
Slipped Epiphysis	7
Muscular Dystrophy	7
Miscellaneous	27

Of the study group, return to regular school programs was anticipated for sixty-nine. Twenty were to transfer to schools for the physically handicapped. Twenty-four would complete their schooling at home. Seven of the pupils had illnesses which were terminal. See Appendix B for more complete information on the students surveyed.[9] [1]

Policies and Procedures for Home and Hospital Instruction

To clarify and standardize procedures citywide, a Manual of the Home and Hospital Instruction Program was distributed to all schools in 1954. Intellectual development was to be such that the child could be educated through a modified classroom program. Although local boards of education had the authority to specify their own minimum time requirement, instruction for less than four weeks did not receive reimbursement from the Office of the Superintendent of Public Instruction. A home, hospital or sanatorium class was defined

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[1] For a more thorough discussion of the homebound program see Clarissa Hug, A History of the Home Instruction Program of the Chicago Public Schools from its Inception Until 1963.

as one where the teacher worked with only one homebound or hospitalized student at a time for an hour each school day.[10]

Program Eligibility. Revised in 1959, the procedural manual stated that children who were expected to be absent for a period of six weeks or longer should be considered for home instructional service. Exceptions were made for high school students, or students near the end of the term, who would be able to secure term credit with the assistance of home teaching. A medical report completed by the child's physician was forwarded to the Bureau of Physically Handicapped Children Students to be hospitalized for a period of two teachable weeks were enrolled in the hospital instructional program. "Teachable" meant that they were physically able to participate and profit from the educational program. Prior to the publication of this manual, most children, regardless of length of stay, were enrolled in the hospital school program.[11]

Since the home and hospital programs were costly and highly specialized, the number of students enrolled was limited by the available staff. A maximum case load was maintained to ensure effective service. Pupils at the kindergarten or 1C levels, the mentally retarded, the seriously ill, and the emotionally disturbed were not eligible for services. Hospitalized students who shared a room with one or more patients, and students requiring intense medical treatment leaving no time for a school program were also not eligible for instruction.

The policy statement excluded students with active pulmonary tuberculosis and prohibited the sending of teachers into any homes which might endanger the health of the staff or the student. Students with hepatitis and infectious mononucleosis had to have passed the period of contagion before a teacher was assigned.

Teachers were expected to see their students twice weekly for a period of one to one and one-half hours. Each student was to receive approximately three hours of instruction weekly. Short term students, expecting to return to their regular school within two to five months, were provided a program closely correlated with the home school. Long term students (five months or longer), and students who would probably not return to their regular schools, were enrolled at Spalding, Burbank, Christopher, or Neil Elementary Schools.[12]

Eligibility requirements changed when Public Law 94-142 called for a "free, appropriate public education for all children." The bill was signed in November 1975 to be effective September 1978. In 1979, the State of Illinois specified that home/hospital services were to be provided to students with an anticipated absence from school of more than two consecutive weeks, and who could be determined to educationally benefit from such a program. Time on the program was to be not less than five hours weekly and sufficient to ensure that the student could return to class with a minimum of difficulty. In addition, related services were to be provided to meet their needs.[13]

Home/hospital teachers were required to hold valid teaching certificates at the elementary or secondary level (or both) at the grade levels of the children with whom they were working. Academic material was to be presented in such a way that the student remained motivated and working to the best of his/her ability.[14]

The elementary course of study consisted of language arts, arithmetic and social studies. Through communication with the student's regular teacher educational exercises were closely linked to the student's home-school program. The wide variety of high school courses and the specialization of teaching certificates made program implementation difficult at the secondary level. Students were limited to three courses, with the exception of those who needed one additional course to graduate. Instructional sessions were to be ninety minutes, twice weekly with all staff teaching English, social studies, history, civics, algebra, geometry, business, typing, and beginning bookkeeping. Other courses were offered only with approval of the supervisor. Students requiring laboratory sciences, shop, or technical subjects in which homebound instructors were not certified, were denied instruction in those areas. This severely limited the ability of students to maintain their class status. This discriminatory policy was often violated and finally removed from the guidelines in 1983. Since then curriculum decisions have been made on a case-by-case basis. However, this still did not provide optimal or equitable services to all students.[15]

Expanded Home/Hospital Services

Telephone Instruction. Funds were budgeted in 1955 for the initiation of a home-school telephone service for students. Considered as a supplement to the homebound program, the telephone was to be used primarily for socialization and for enrichment. Teachers could refer students who were: 1) average or better in intelligence; 2) at or above the seventh grade level; 3) expected to remain at home for at least one year; 4) motivated academically and able to work independently; and 5) supported by a high degree of parental cooperation. Speaker microphones were installed in the classroom and the student's home. Students who could actively participate, tended to make better progress, and had better morale.[16]

The effect on the classroom students was positive as well. They made continuous effort to speak clearly and distinctly, and to describe experiments or maps to their confined classmates. Home teachers visited twice a week to present visual aids, give tests, and discuss interests and concerns of the student.[17]

Teleclass units were installed at Christopher and Spalding schools in 1979. These units were intended to provide instruction to groups of at least ten selected students at the upper elementary and high school levels. There were many anticipated benefits. Educational services could be provided for those students in which an adult could not be present during the time of the instruction, or in those cases where infectious disease might endanger the teacher and other students.

Although the state provided reimbursement for an approved home-to-school telephone class, the program was never widely implemented and the initial enthusiasm waned. Many students were not able to pay close attention to phone instruction despite their careful selection for the program. Also the law still required home visits so it was not cost effective.[18]

<u>Hospital School Refinements</u>. A trend toward shorter hospitalizations and the increased need for home teaching provided the impetus for a study on enrollment fluctuation in the hospital teaching program in 1957. A variation of approximately 24 percent between the low and high enrollments of the year was found. Existing home staff were so busy that it had become necessary to reduce the number of visits to once a week for most students. To effectively use teacher time, hospital staff were assigned home students when case loads were low. Only a few students at that time received two

weekly sessions. However, there was a full day program at Booth Memorial Hospital for pregnant girls. This program was so successful that the hospital began to accept patients early enough to allow them to complete a full semester of school work during their stay. The hospital administration felt that the educational program made a great contribution to the psychological and social rehabilitation of the girls.[19]

Mental Health and Hospital Instruction. In February 1952, the Child Care Inpatient Unit opened at Michael Reese Hospital. This was one of the first psychiatric units to receive educational services. During the first ten months, twenty-seven children were admitted to the unit which was intended to house ten children between the ages of six and twelve. The children were divided into three groups: severe compulsive-obsessive and neurotic syndromes; psychosomatic illnesses; and defective, brain-injured or undiagnosed problems. The length of stay ranged from 1-294 days.[20]

After the usual admission routines had been completed the child was given both formal and informal assessments of his/her ability to participate in schooling. Students attended school three mornings per week and received credit for physical education and crafts on a fourth afternoon. Three afternoons a week were devoted to adolescent group recreational activities which included educational trips. The students were actively involved in the planning.[21]

As the number of child and adolescent psychiatric patients grew, a high school program was established at Michael Reese in 1957. By 1966, the staff had four teachers who offered courses at all grade levels so that students could maintain their academic status and graduate on schedule. The required courses in English, social studies, algebra, geometry and biology were taught in the hospital school. Some students, with the consent of their physician, attended math and science classes at Dunbar High School.[22]

The high school program sought to provide a corrective and therapeutic classroom experience, to represent age appropriate reality demands, and to help students achieve academic credits. Special teaching methods which included team teaching were used. School trips and special long range group projects were incorporated in the program to build student self-esteem and to help maintain interest. An example was an original thirty minute movie written, performed, filmed, edited, and presented by the adolescents. It was based on their classroom subjects and was a reflection of their experiences in a psychiatric hospital.[23]

<u>Psychiatric Hospital Schools</u>. The American Society for Adolescent Psychiatry, the National Association of Private Psychiatric Hospitals, and the American Psychiatric Association organized a panel on "The Educational Needs of Adolescents in Psychiatric Hospitals" for the national meeting

of the American Psychiatric Association in May 1970. This provided an opportunity for many differing attitudes, thoughts and solutions to be presented and reviewed by the practitioners in the field. Here the educational and therapeutic models were also examined.[24]

Robert A. Solow suggested that the role of the residential hospital educational program was to provide each teenager with a positive and meaningful academic and social learning experience. To do so each student should be viewed in terms of his academic, intellectual, social and emotional needs, and an educational baseline should be established. This information was to be based on the full range of interests, activities, and techniques to achieve individual goals. A complete diagnostic workup to measure patient [student] strengths and weaknesses was to be completed by a team of professionals. These needs of the adolescent, not the curriculum, would provide the framework for the school program. It was felt that the teacher had to accept the student at his/her own level of intellectual, academic, and emotional capabilities. The teacher could thus make a significant contribution to treatment and rehabilitation in an atmosphere which provided successes and not failures.

The hospital school provided an opportunity to relearn and reorganize as well as remediate academic deficiencies. Negative attitudes toward, school, classmates, teachers, as well as subject matter, could be modified by providing successful learning experiences through positive teacher-pupil relationships. The hospital teachers held the same role in and outside the hospital setting. They were able to assist the adolescent in reality testing, in learning to set limits, in dealing with peer and adult authority figures, as well as gaining essential skills and information which would aid in the transition back to the regular school program. The school became important to the implementation of treatment goals established in the individual treatment plan. Once confidence began to grow, the students could be moved to a more typical school program.[25]

During the 1970s the number of psychiatric units and psychiatric hospitals grew as the numbers of general medical units reduced their inpatient capacity. As a result, many teachers were reassigned to psychiatric facilities or units. This was not a satisfactory arrangement. Most of the assigned teachers held only physically handicapped certification; they were not prepared to deal with these disturbed students. The hospital staff expected teachers to become contributing members of their therapeutic team: a role some teachers could not accept. The requests for longer school sessions could not be provided with the limited staff. In response, several of the hospitals initiated their own school programs with their own teaching staff. Initially these private educational services were provided at no cost to the Chicago schools. However, in 1983, reimbursement agreements were reached with three psychiatric hospitals. This arrangement solved some problems, but created others related to coordination of academic programs and transfer of credits to the local schools.

Other Changes in Hospital Instruction. Although teaching services were being provided to students hospitalized at facilities with large school aged populations, the students at small hospitals were denied education for many years. Finally, in 1973, itinerant hospital teachers were assigned. All referrals were made through the Bureau of Physically Handicapped Children which assigned teachers on a case-by-case basis.[26]

Hospital teachers enrolled non-Chicago students under a reciprocal arrangement with other Illinois districts in which hospitals were located. Under this agreement, educational services were exchanged. In 1981 the Proviso district initiated a policy which excluded Chicago students. The program had become too expensive for their small district. Shortly thereafter, the Illinois State Board of Education directed that tuition be charged for educational services provided to out-of-district students. However, this has never brought full reimbursement to the Chicago school system because of collection difficulties.[27]

During the late seventies and early eighties, the mandates of the new law brought increasing numbers of students to homebound instruction. At the same time, the tenure of hospitalized students continued to decline with improved medical care and more careful insurance monitoring. Hospital teaching staff were reassigned to homebound. Program demands and personnel shortages were compounded by growing financial problems.

Chronic Health Impaired Program

A chronic illness is one that is of long duration. All are conditions which may interfere with daily functioning in some way and limit ability to engage in normal activities. Frequently the illness produces maladaptive coping strategies by both the child and the family. It has been estimated that 10 to 15 percent of all children have chronic health conditions. Of this group, about 10 percent are severe enough to interfere with daily activities. The Education for All Handicapped Children's Act (94-142) in 1977 defined other health impaired children as:

> having limited strength, vitality, or alertness due to chronic or acute health problems such as heart conditions, epilepsy, tuberculosis, rheumatic fever, nephritis, asthma, sickle cell anemia, hemophilia, lead poisoning, leukemia or diabetes which adversely affects a child's educational performance.[28]

The chronically ill children had frequent, short term school absences.[29] Thus high absenteeism resulted in failure--especially at the high school level. A large percentage of these students dropped out. Increasing concerns began to be voiced by teachers, administrators, parents, and medical personnel regarding the lack of services to this constituency.[30] In 1981, a survey was conducted in five selected subdistricts to determine the extent of the need. The students surveyed attended regular school but averaged sixty-three days of absence per year. This resulted in high failure rates, low self esteem, and increased drop out rates. Yet few of these students had been absent for two consecutive weeks thus disqualifying them for services in the home-hospital program.

A concept paper was presented to the director of the bureau of physically handicapped children citing the survey of 1981. It was based on the Sickle Cell Anemia Program (SCAP) of Baltimore, Maryland and suggested that the bureau utilize local funding. In September 1981 the Chronic Health Impaired Program (CHIP) was initiated. One elementary teacher was assigned and spent part of the day at Children's Memorial Hospital and part at Michael Reese. Two high school teachers were made available as well. Service was provided only to students when they were hospitalized. All efforts were directed toward providing experiences which would allow the child to return to school at the same level as his/her class.[31]

After a period of two months, it became apparent that the number of students enrolled in the program was greater than the staff could successfully serve. Questions were raised regarding patients at other facilities. How might they be identified? The Superintendent's Bulletin carried the announcement to all schools. Many new referrals came from school personnel and medical staff. In January, 1983, all hospital teaching staff began to enroll chronically ill students. During the six month period from January to June 1983, 207 chronically ill students were served. The largest groups were asthma patients (91) and sickle cell and thalassemia patients (61). Patients with cancer and renal failure made up the third largest group. Project evaluation indicated sufficient need to warrant continued involvement with the targeted population.

Beginning September, 1984, only selected children were enrolled in the CHIP program. Referrals of chronically ill students by medical personnel were screened by school staff. Only students with academic deficits and with absences in excess of thirty school days were determined to be eligible for the program. Students were assigned to teachers who provided instruction at home and in the hospital. Teacher case load averaged fifteen elementary students and ten at the high school level. Additional instruction time was provided at the child's school as needed. The program resulted in improved student test scores and was cost effective for the system. However, financial constraints hampered full service to all eligible students. By 1984-85 the experiment had become a regular program offering.

Summary

Growing from the desire to meet the needs of handicapped children, the first hospital for orthopedically handicapped youth was established at the Home for Destitute Crippled Children. It fit well with the ideas embodied in the progressive tenets at the turn of the century that put the interests and needs of the child first. Their by-laws mandated an educational program two hours daily. Within a short period of time the Chicago schools adopted the program and established the first school for crippled children. Transportation to and from class was provided daily.

Societal interest in improving the health of children grew during the tuberculosis epidemic. This interest spurred the initiation of open-air and open-window school programs. Intensive medical care was a major component of these innovations. During this same time teaching programs were initiated in most hospital pediatric units and convalescent homes. Home instruction began with the polio epidemic of the 1940s. This type of instruction was warmly received when initiated. It resulted in increasing pressure from medical staff and parents to provide educational programs to all confined children but financial constraints prevented serving all who qualified. Some waited for as long as six months for service. Attempts at solving this dilemma were unsuccessful and remained a problem for years to come.

The mentally handicapped, behavior disordered and emotionally disturbed children admitted to hospitals now received educational services. The need was great but, once again, the funds were limited. Administrators tried to "hold the line" against rising expenses. Identification of new students increased the problem of adequate staff coverage for students needing home/hospital instruction. Waiting lists grew longer. Declining revenues prohibited the hiring of additional teachers. To further compound compliance problems, teacher assignments were based upon availability rather than appropriate certification. Staff members were required to hold physically handicapped endorsements rather than certification based upon identified student needs.

In order to provide service to more students, individuals were limited to the five hour minimum of instruction per week. A few received the supplementary support of a teleclass teacher for additional instruction, but this cooperative arrangement was rare due to the difficulty in getting instructors to teach effectively over the phone.[32] Services to pregnant girls varied over the years but were generally negligible. Societal attitudes resulted in many girls leaving school early. Of those who remained, few were referred for services.

Coordinating attendance and credits was problematic to the program. Procedures called for transferring students to schools for the physically handicapped during their period of confinement. Local schools frequently refused to accept credits earned at these schools and in some cases dropped the student from their membership.

The number of children not receiving proper educational services increased to disgraceful proportions. Insufficient and unqualified staff accompanied by organizational constraints further compounded the problems. Difficulty in receiving credit for academic work, and failure to fully implement the individualized educational programs of special education students were major concerns.

In the next section we will consider the major programmatic reorganization that was essential to solve these problems. The changes brought about by decentralization will be reviewed. Further innovations will be suggested.

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AFTERMATH[1]

The number of students requiring homebound service increased as improved medical procedures and escalating costs limited hospital stays. Advocates also raised concerns about the educational neglect of the chronically ill. Although the CHIP program provided for many, more and more pupils went unserved.

Growing financial problems focused attention on programs with high per pupil costs. A review of the funds allocated to service the target population raised concerns about the cost effectiveness of the model in place. To increase efficiency, all home and hospital personnel were reassigned from schools to a citywide service unit effective September 1989. This freed 10 additional teachers to provide direct service.

More students received instruction, but many deficiencies went unresolved. Analysis of staff activities revealed much time was spent coordinating student academic information with home school staff. Travel consumed at least one hour daily for each teacher. By May 1990 there were seventy-seven home/hospital teachers but 165 eligible students were waiting for services and many more remained unidentified. The hourly per pupil cost of $45.00 quickly consumed the $3.2 million annual budget. Pregnant girls were especially underrepresented. In May 1990, two complaints were filed with the United States Department of Education, Office of Civil Rights (OCR) regarding home and hospital instruction. Charges included insufficient instructional time, lack of provision of related services, and inadequate services to chronically ill students.[2]

In August 1990, a new associate superintendent, was employed to restructure the Department of Special Education and Pupil Support Services to comply with the mandate of school reform legislation passed by the state legislature. These combined influences set the stage for a major programmatic reorganization.

To resolve the OCR complaint, Ted D. Kimbrough, General Superintendent of Schools, signed a statement called Assurances which promised that the school system would make the necessary changes to fully comply with the law. With technical assistance provided by the Illinois State Board of Education (ISBE) tasks were mandated to bring the school system into compliance. A full copy is found in the appendix.

The study of other school systems narrowed the focus to a model utilized in the Boston and Indianapolis Public Schools. Consultation with representatives of these systems was followed by contact with staff of the major medical centers in the Chicago area regarding perceived home/hospital instructional needs. Program guidelines were adopted following review by the OCR and ISBE.

Dr. Thomas Hehir, Associate Superintendent for Special

Education and Pupil Support Services, presented the program and comprehensive training to principals at an administrator's academy in August 1991. These sessions were held to ensure that current information was available to all school staff and that no eligible students would be overlooked. Correspondence was sent to major medical centers regarding the reorganization. Parents of current home students were notified of the changes. Nurses received the new guidelines the first day of school.

The reorganization became effective September 1991; the first major innovation in forty years. This new model offered several service improvements. Based upon eligibility determined at the local school level, instruction could begin as soon as the student was identified and the teacher was assigned. Local school principals were given the opportunity to employ the student's classroom teacher to provide continuing instruction at home. Other appropriately certified staff from the local school could also serve the child. A citywide pool of teachers was developed should no local staff member be interested in homebound instruction. High school students were programmed with two or three subject specialists as needed. This resolved difficulties in identifying certified teachers qualified in technical subjects, languages, or laboratory sciences. Any qualified staff member could be employed. Fifteen specialized full time teachers were retained to provide instruction to hospitalized students at major medical centers.

Educational planning at the local level included the determination of the length of the daily instructional session. Students received a minimum of one hour of instruction unless medically contraindicated. The Individual Education Plans (IEP) of special education students were implemented in the home setting and included related services.

Utilizing the student's own teacher solved many of the problems of coordination of academic activities and greatly reduced transition concerns. The classroom teacher, with knowledge of the curriculum as well as of the specific needs of the student, could continue instruction with the same textual materials used in class. This opportunity for one-to-one tutoring allowed for the remediation of deficits as well as the growth of student-teacher rapport. Instruction was scheduled immediately before or after school at the convenience of the parents and with consideration of the health needs of the child. Teachers became increasingly sensitive to the specific learning and interpersonal styles of their home students. Their improved understanding of diverse cultural, racial, and linguistic backgrounds reaped benefits for in-school students as well.

A computerized data entry system served as a basis for the home/hospital state reimbursement claim for both students and special education personnel. This technological advance enabled staff to access one data source regarding the students special problems: a very useful tool in determining trends and future needs.

On 27 May 1992, Dr. Hehir presented background and updated information on the Home and Hospital Program to the Committee on Instruction of the Board of Education. Statistics indicated that more students were served than in previous years with a projected saving of $1 million by eliminating the travel and fringe benefits of the full time staff. This new program brought the system closer to compliance with federal and state regulations.[3]

Although a great deal has been accomplished in a short time, much remains to be done. Prereferral and referral strategies must be refined to ensure that all eligible students receive homebound services. Care must be taken to prevent the enrollment of chronic truants and discipline problems to improve the schools average daily rate of attendance and eliminate disruptive children from the school program.

The classroom teacher, nurse, home/hospital case facilitator, principal, the parent, and others as needed, should determine what services are appropriate in addition to home or hospital instruction. In-school instructional modifications, program adaptations, or consideration for transportation may meet student's needs without requiring homebound services. Cooperative and innovative planning is essential; especially for those referred due to psychiatric or chronic health problems. The student's medical team must be included to assure maximum educational and medical benefits for each child.

It is anticipated that related services will continue to expand in type, quantity, and variety. Currently staffing remains a problem because trained speech, physical and occupational therapists can receive greater salaries for providing private health services than public educationally based therapies. To meet the needs, staff therapists currently consult with homebound teachers to provide some interventions as part of an integrated educational program. We must recruit and maintain these specialists.[4]

The system must attract trained personnel willing to provide services at home to needy students. Safety concerns must be addressed. This includes providing teachers with current information on the transmission of aids, hepatitis B, and other contagious diseases. Discussions must include ways to safely negotiate violence ridden neighborhoods and buildings in our inner city.

Anticipated advances in technology will greatly reduce the functional limitations of persons with disabilities. Acquisition of necessary equipment and trained staff must be made available in a timely fashion to all homebound students should the need be permanent or temporary. Increased use of communications technology will greatly expand the program options by means of teleconferencing, home-class speaker phones, or such devices as the Visitel picture phone used in the Orange County Public Schools. This allows increased instructional time and provides reinforcement to enhance program options for pupils.

Program monitoring and study will be one of the most difficult challenges. Research that addresses the effectiveness of the instruction, as well as the timeliness of the interventions, will be particularly important to achieve maximum efficiency. Staff must be held accountable for quality home instruction.

Isolation is one of the major problems of home and hospital teachers and administrators. It is essential to maintain peer contact. Interdistrict meetings of home/hospital administrators and staff will allow for collegial sharing of ideas and techniques which may be adapted to local use. Inservice training of homebound teachers must be ongoing. Information on disabilities and illnesses may be provided by nurses, social workers or home/hospital specialists. Medical staff, parents and former home/hospital students should be asked to participate in teacher training sessions.

Techniques for working with families and students in crisis is extremely important. Sensitive discussions on death and dying are necessary if terminal students are to have fulfilling lives. It is essential for principals to have clear and precise information regarding the illness or disability and the prognosis of students to ensure that the selected staff member is able to successfully complete the assignment.

CONCLUSION

The development of the Home and Hospital Program has been entwined with the growth of the medical profession and the proliferation of hospitals. Individuals who initiated the first hospital teaching program provided the stimulus for the development of schools for crippled children and programs for all physically handicapped. Improvements in the provision of services to hospitalized and homebound students was not smooth or consistent. Dedicated teachers maintained the 'front line' while administrators responded to, rather than initiated, program development. Since 1950 only one major reorganization has attempted to improve direct services to students and this came from pressures brought to bear upon the programs by the OCR. With school reform and the widely divergent goals of some local school councils, it remains to be seen if the early effectiveness of this reorganization will persist. Over the years the charge has not changed. The words of Mrs. Frances Mullen, Associate Superintendent of Special Education in 1956 are still timely.

> Today special education has a particular challenge. Medicine is making advances that reduce some handicaps, and increase the numbers of others, as more lives are saved. New advances in psychology, social understanding, and education are ready to be called to our aid. Community awareness of the

problem of delinquency and community understanding of the needs of the mentally handicapped are growing rapidly. There are children with one severe handicap or with a combination of handicaps, who present problems so difficult that we have not yet been able to figure out ways to help them. Special education cannot remain static. It must meet new conditions; it must find better solutions to old problems.[5]

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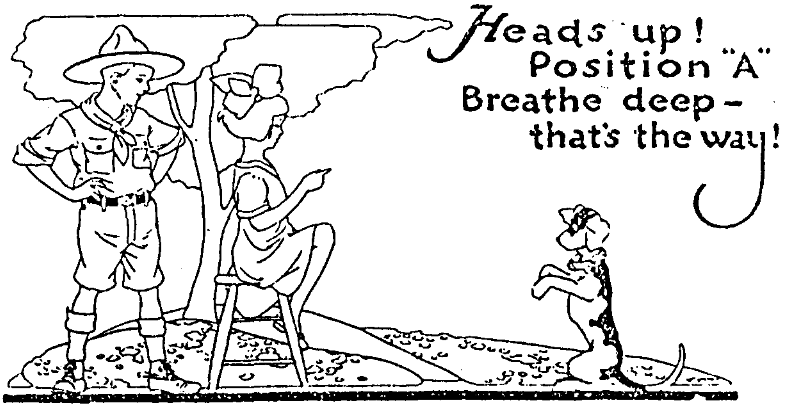
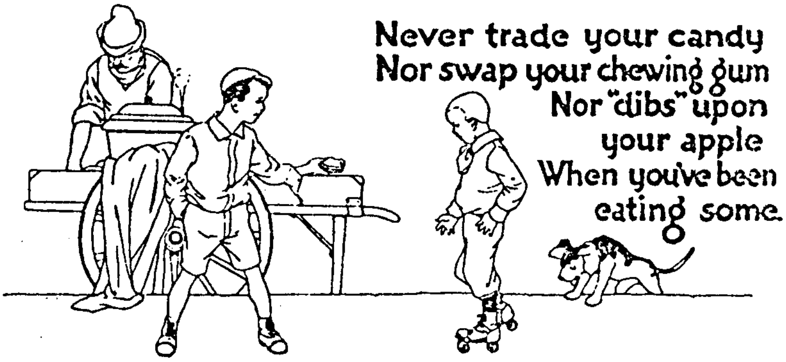
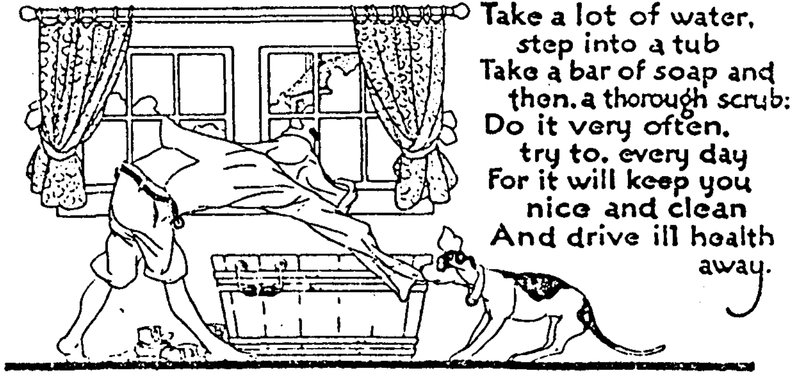
APPENDIX

APPENDIX A







Three of the set of nine colored posters issued by the Chicago Tuberculosis Institute.

APPENDIX B

Chicago Public Schools
Benjamin C. Willis
General Supt. of Schools

Department of Special Education
Francis A. Mullen
Asst. Supt. of Schools

STATISTICAL STUDY OF PUPILS RECEIVING HOME INSTRUCTION CHICAGO PUBLIC SCHOOLS, OCTOBER 10, 1954

TABLE I
SEX AND SCHOOL PLACEMENT

	Elementary		High School		Total	
	No.	Percent	No.	Percent	No.	Percent
Boys	41	54.7	22	66.6	63	58.3
Girls	34	45.3	11	33.3	45	41.6
Total	75	100.0	33	99.9	108	99.9

TABLE II
GRADE DISTRIBUTION

	NUMBER	PERCENT
Grade 1	7	9.3
2	6	8
3	7	9.3
4	9	12
Grade 5	13	17.3
6	9	12
7	12	16
8	12	16
Grade 9	9	27.2
10	7	21.2
11	12	36.3
12	5	15.1

APPENDIX C

ASSURANCES

To resolve compliance issues identified during the Office for Civil Rights' (OCR) investigations of complaints 05-90-1107 and 05-90-1121 concerning the homebound/hospital program operated by the Chicago Public Schools, District #299 (District), the District agrees to:

1. These assurances apply to students of school age who are unable to attend school on an extended or chronic basis because of a documented physical or mental impairment, and who are determined to be qualified handicapped persons under 34 C.F.R. 104.3(j) and (k). "Extended absence" is defined as an absence that will be more than 10 consecutive school days. "Chronic absence" is defined as a series of absences each of 10 days or fewer in duration that creates a pattern of absences constituting either a significant change in placement or a significant interruption of education.
2. By the end of the first semester of the 1990-1991 school year, the District will develop, describe, and implement a home/hospital program that is reasonably calculated to meet the educational needs of students described in paragraph one above. In developing this program, the District will consult with school professionals having expertise in the provision of educational services to

students in home/hospital programs to identify effective strategies for: identifying students eligible for services at home or in the hospital; evaluating individual student educational needs and developing individual program planning documents; assigning teachers and related service providers trained to provide the services needed by each student; establishing criteria for assigning staff to hospitals on a case-by-case or permanent basis, for example, in the case of a children's hospital; transition planning for students returning to local schools; and recordkeeping. A copy of the District's description of its homebound/hospital program will be provided to OCR by February 15, 1990.

3. By the end of the first semester of the 1990-1991 school year, the District will develop and implement procedures governing the administration of its home/hospital program that conform with the requirements of 34 C.F. R. 104.33, 104.34, 104.35, and 104.36. The procedures will, at a minimum:
    a. set standards for determining whether a child has "chronic absences"' from school because of a physical or mental impairment;
    b. require the identification, referral, and evaluation of students who may be handicapped and the design and provision of regular or special education and related aides and services to those

students who have been determined to require through procedures consistent with 34 C.F.R. 104.35, homebound/hospital services based on their individual; educational needs. The procedures will, at a minimum:

1. establish a reasonable time frame for the evaluation and educational program design process and the provision of educational services;
2. describe the evaluation process, which will include consultation with the student's parents/guardians, the student's regular school teacher, and pertinent medical staff to determine whether the student's current regular or special education and related aides and services requires modification because of medical necessity; and
3. requires the design of a written educational plan that meets the individual needs of each student. For students who are chronically ill, this plan will include a component for consultation between the homebound/hospital teacher and regular school teacher to facilitate transition to and from the regular school program.

d. establish protocol for the assignment of staff trained to provide the educational services needed for each student and for the provision of educational services in a small group or classroom setting;

e. require for each student upon discharge from the homebound or hospital program an evaluation utilizing procedures consistent with 34 C.F.R. 104.35. The evaluation will include consultation with the student's parents/guardians, the student's homebound/hospital teacher, the student's regular teacher, and pertinent medical staff to design an educational program that meets the needs of the handicapped student, considering transition back to the student's regular education program;

f. require that a record of each student served in the District's homebound/hospital program be maintained in a central location and that such record identify the student's local school. The student's homebound/hospital educational file will be incorporated in the student's regular educational file maintained at the local school; and

g. require that each student's educational file document:

1. the evaluation process, including consultation with appropriate medical and educational staff;

2. the medical basis for any shortened school day program recommended for a student, taking into consideration the student's receipt of educational services on a one-to-one or small group basis;
3. the educational program designed for the student that describes the regular or special education and related aides and services the student needs while hospitalized or at home in order to receive an appropriate education;
4. the implementation of the student's educational program;
5. the transition plan designed for the student no longer requires homebound or hospital services; and
6. parental/guardian notice of procedural safeguards with respect to actions regarding the identification, evaluation, or educational placement of their children.

By February 15, 1991, the District will provide OCR a copy of the procedures developed pursuant to this paragraph.

4. By the end of the first semester of the 1990-91 school year, the District will provide to appropriate school staff a

copy of the procedures governing the District's home/hospital program, as described in paragraph 3 and training on their implementation. By February 15, 1991, the District will provide OCR documentation that this activity has been completed.

5. By the end of the first semester of the 1990-91 school year, the District will prepare for and disseminate to parents and guardians a written summary of the procedure governing the District's home/hospital program. Thereafter, this information will be provided to parents and guardians of students newly enrolled in the Chicago Public Schools. By February 15, 1991, the District will provide OCR documentation that the information has been disseminated to parents and guardians of students currently enrolled in the District.

6. By the end of the second semester of the 1990-91 school year, the District will provide to OCR access to educational files for 25 randomly selected handicapped students receiving educational services at home and in the hospital.

Ted M. Kimbrough
General Superintendent of Schools or
his designee

10-11-90
Date

APPROVAL SHEET

The dissertation submitted by Vivian E. Rankin has been read and approved by the following committee:

Dr. Joan K. Smith, Director
Professor, Educational Leadership and Policy Studies
Associate Dean, Graduate School
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Dr. Martha Wynne
Professor, School of Education
Loyola University Chicago

Fr. Michael Perko
Professor, School of Education
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Professor, Department of Special Education
Northeastern Illinois University

The final copies have been examined by the director of the dissertation committee and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the dissertation is now given final approval by the Committee with reference to content and form.

The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

19 April 1993

Date

Joan K. Smith

Director's Signature