Faculty Handbook
Introduction

The purpose of the Office for Students with Disabilities is to provide reasonable accommodations for students with documented disabilities. Section 504 of the Rehabilitation Act of 1973 defines an individual with a disability as a person who “has a physical or mental impairment which substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment.” The “Section 504 Compliance Handbook” states that physical impairments include such things as physiological disorders, contagious diseases, cosmetic disfigurements or anatomical losses in one or more of the following systems: neurological, musculoskeletal, respiratory, cardiovascular, reproductive, digestive, genito-urinary, hemic, lymphatic, skin, or endocrine. Mental or psychological disorders include conditions such as mental retardation, organic brain syndrome, emotional or mental illness, and learning disabilities. Major life activities include self-care, manual tasks, walking, seeing, hearing, speaking, breathing, sitting, standing, reaching, thinking, concentrating, reading, interacting with others, learning, reproducing, sleeping, and working. Students are responsible for providing documentation of their disabilities to the OSD from a qualified diagnostician or health professional in the appropriate field. Accommodations are then determined by OSD personnel and approved by the Director. Support services include the proctoring and administration of classroom and placement tests, academic advisement, the services of a learning disabilities specialist, use of adaptive furniture and software, services of a sign language interpreter, assistance with course substitution and test waivers, and other services, as needed. All services are free, and information is kept confidential and cannot be released without permission from the student.

The second major service that the OSD provides is that it serves as a resource for faculty and staff. Personnel from the office will speak in SLS classes and others as requested, and will also speak at department meetings. If faculty members have concerns about a particular student and they believe that the student might have a disability, they should not hesitate to contact the OSD for suggestions. Additionally, if a faculty member has a question regarding the accommodations that have been

approved for a student, or if he/she would like information as to how to better serve a student with a specific disability, that professor should contact the Director of the OSD at extension 63607.

OFFICE FOR STUDENTS WITH DISABILITIES

Personnel

Lyndi K. Fertel, Director – ext. 63607, 32185

Titusville

Paula Higginbotham, Disability Services Specialist	ext. 42011

Cocoa

Chris Pierce, Disability Services Specialist	ext. 63606
Nancy Spotz, Learning Disabilities Specialist	ext. 63664
Vicki Cordon, Learning Specialist/math	
Patty Smith, Learning Specialist/English	

Melbourne

Tara Andersen, Disability Services Specialist	ext. 32180
Nancy Malta, Learning Disabilities Specialist	ext. 33171
Britta Moore, Learning Specialist/English	
Robert Tulier, Learning Specialist/math	
John Nanna, Assistive Technology Specialist	ext. 32580

Palm Bay

Lynn Dallas, Disability Services Specialist	ext. 22019

Learning Disabilities - To be tested for a learning disability, a student must be enrolled in classes at BCC. He/she should call the LD specialist for an appointment. Nancy Spotz (ext. 63664) tests students on the Titusville and Cocoa campuses. Nancy Malta (ext. 33171) tests students on the Melbourne and Palm Bay campuses. The testing takes from 5-6 hours and is broken into parts over several days. There is no charge for the testing.

Speaker - Lyndi K. Fertel (ext. 63607) will be glad to speak in any class, during the day or evening, about the Office for Students with Disabilities.

LAWS/DEFINITIONS

Section 504 of the Rehabilitation Act of 1973 (PL 93-112)

This statute states that no otherwise qualified individual may, because of his/her disability be denied access to, the benefits of, or be subject to discrimination by any program provided by an institution or entity receiving federal financial assistance. It is Section 504 that prompted the development of support services for people with disabilities in institutions of higher learning. It also prohibits discrimination in admissions procedures, treatment after admission, and in recruitment and testing. While schools must make appropriate academic adjustments to permit full participation of students with disabilities, the essential nature and requirements of the course or the curriculum are not to be altered.

The Americans with Disabilities Act of 1990 (PL 101-336)

The original intent of this Act was to afford people with disabilities the same rights as those groups listed in the Civil Rights Act of 1964 (based on race, color, sex, national origin, and religion). Whether or not any operational funds are received from the federal government, the agency/institution/business may not discriminate on the basis of disability. All people residing in the United States are covered by this whether or not they are citizens and without regard to racial or ethnic origin.

Disability

The ADA defines a person with a disability as being someone with a physical or mental impairment that *substantially limits* one or more of his/her major life activities. One is considered to have a disability if he/she presently has it, has a record of the impairment, or is regarded as having it.

> *substantially limits* – this means that in comparison to the "average" person or to most people, he/she is unable to, or is significantly restricted as to the condition, manner, or duration under which a major life activity can be performed

Disability Defined

"Person with disability" means an individual who: (1) has a physical or mental impairment that substantially limits one or more major life activities; (2) has a record of such an impairment: or (3) is a regarded as having such an impairment.

<table>
<tr><th colspan="2">Physical or Mental Impairment</th><th>Major Life Activities</th><th>Record of Impairment</th><th>Regarded Impaired</th></tr>
<tr><td>Physiological disorder, contagious disease, cosmetic disfigurement or anatomical loss in one or more system:</td><td>Mental or psychological disorder including:</td><td>Major life activities include:</td><td>The individual has:</td><td>The individual has:</td></tr>
<tr><td>Neurological
Musculoskeletal
Respiratory
Cardiovascular
Reproductive
Digestive
Genito-urinary
Hemic
Lymphatic
Skin
Endocrine</td><td>Mental retardation
Organic brain syndrome
Emotional or mental illness
Specific learning disabilities</td><td rowspan="2">Self-care
Manual tasks
Walking
Seeing
Hearing
Speaking
Breathing
Sitting
Standing
Reaching
Thinking
Concentrating
Reading
Interacting with others
Learning
Reproducing
Sleeping
Working</td><td rowspan="2">A history of impairment

or

A record of having been misclassified as having an impairment</td><td rowspan="2">An impairment not limiting a major life activity, but is treated as disabled by the covered entity

No impairment, but is treated as disabled by the covered entity</td></tr>
<tr><td colspan="2">Substance abuse*</td></tr>
</table>

* Does not include current, illegal drug users.

President's Committee on Employment of People with Disabilities

Communicating With and About People with Disabilities

The Americans with Disabilities Act (ADA), other legislation, and the efforts of many disability organizations have begun to improve accessibility in buildings, increase access to education, open employment opportunities, and develop realistic portrayals of persons with disabilities in television programming and motion pictures. However, more progress needs to be made. Many people still view persons with disabilities as individuals to be pitied, feared, or ignored. These attitudes may arise from discomfort with individuals who are perceived to be different or simply from a lack of information. Listed below are some suggestions on how to relate and communicate with and about people with disabilities. We must look beyond the disability and look at the individual's ability and capability -- the things that make each of us unique and worthwhile.

Words

Positive language empowers. When writing or speaking about people with disabilities, it is important to put the person first. Group designations such as "the blind," "the deaf," or "the disabled" are inappropriate because they do no reflect the individuality, equality, or dignity of people with disabilities. Following are examples of positive and negative phrases. Note that the positive phrases put the person first.

Affirmative Phrases	**Negative Phrases**
person with mental retardation	retarded, mentally defective
person who is blind, person who is visually impaired	the blind
person with a disability	the disabled, handicapped
person who is deaf, person who is hard of hearing	suffers a hearing loss, the deaf
person who has multiple sclerosis	afflicted by MS
person with cerebral palsy	CP victim
person with epilepsy, person with seizure disorder	epileptic
person who uses a wheelchair	confined or restricted to a wheelchair
person who has muscular dystrophy	stricken by MD
physically disabled	crippled, lame, deformed
person without disability	normal person (implies that the person with a disability isn't normal)
unable to speak, uses synthetic speech	dumb, mute
seizure	fit
successful, productive	has overcome his/her disability; courageous (when it implies the person has courage because of having a disability)
person with psychiatric disability	crazy, nuts
person who no longer lives in an institution	the deinstitutionalized
says she/he has a disability	admits he/she has a disability

Actions

Outlined below are the "Ten Commandments of Etiquette for Communicating with People with Disabilities" to help you in communicating with persons with disabilities.

1. When talking with a person with a disability, speak directly to that person rather than through a companion or sign language interpreter.
2. When introduced to a person with a disability, it is appropriate to offer to shake hands. People with limited hand user, or who wear an artificial limb can usually shake hands. (Shaking hands with the left hand is an acceptable greeting.)
3. When meeting a person who is visually impaired, always identify yourself and others who may be with you. When conversing in a group, remember to identify the person to whom you are speaking.
4. If you offer assistance, wait until the offer is accepted. Then listen to or ask for instructions.
5. Treat adults as adults. Address people who have disabilities by their first names only when extending the same familiarity to all others. (Never patronize people who use wheelchairs by patting them on the head or shoulder.)
6. Leaning on or hanging on to a person's wheelchair is similar to leaning or hanging on to a person and is generally considered annoying. The chair is part of the personal body space of the person who uses it.
7. Listen attentively when you're talking with a person who has difficulty speaking. Be patient and wait for the person to finish, rather than correcting or speaking for the person. If necessary, ask short questions that require short answers, a not or shake of the head. Never pretend to understand if you are having difficulty doing so. Instead, repeat what you have understood and allow the person to respond. The response will clue you in and guide your understanding.
8. When speaking to a person who uses a wheelchair or a person who uses crutches, place yourself at eye level in front of the person to facilitate the conversation.
9. To get the attention of a person who is deaf, tap the person on the shoulder or wave your hand. Look directly at the person and speak clearly, slowly, and expressively to determine if the person can read your lips. Not all people who are deaf can read lips. For those who do lip-read, be sensitive to their needs by placing yourself so that you face the light source and keep hands, cigarettes, and food away from your mouth when speaking.
10. Relax. Don't be embarrassed if you happen to use accepted, common expressions such as "See you later," or "Did you hear about that?" that seems to relate to a person's disability. Don't be afraid to ask questions when you're unsure of what to do.

The information for this fact sheet came from three sources: The President's Committee on Employment of People with Disabilities, Guidelines to Reporting and Writing About People with Disabilities, produce by the Media Project, Research and Training Center on Independent Living, 4089 Dole, University of Kansas, Lawrence, KS 66045, and Ten Commandments of Etiquette for Communicating with People with disabilities, National Center for Access Unlimited, 155 North Wacker Drive, Suite 315, Chicago, IL 60606

October 1995

Suggestions for Advisors

Please remember that **you may not ask students if they have a disability**. Some disabilities are obvious, but many, such as learning disabilities, ADD, certain head injuries, diabetes, HIV, asthma, chemical dependence and other conditions and diseases, might be invisible. The largest percentage of those disabilities is those with learning disabilities and/or ADHD, however, so be aware of any of the following which might indicate that students have one of these conditions: they cannot seem to stay still in heir chairs: they do not seem to be paying attention: they say you a question that you just answered: they make inappropriate comments: they are distracted by every little noise or motion: they mention that they received services in the past or were in special classes.

Listen, non-judgmentally, to what the students say about their past academic history, learning style, health, behavior, family history, hospitalizations, accidents, etc. After establishing a good rapport, you might want to ask the students if they have ever received tutoring or assistance in any subject.

Learn students' academic strengths, weaknesses, and interests. This will enable you to assist them in registering for a good "mix" of classes where they won't be taking all those subjects that cause problems for them at the same time.

Students with learning disabilities often misperceive the progress they are making in courses or are overly optimistic concerning how they perform academically. Encouraging students not to register for courses that might be too difficult for them and not take an overly heavy course load. Because people with LD's often suffer from poor self-esteem, it is more **important for the student to experience success** than for him/her to take a heavy course load.

Warn students that they might take longer than two years to graduate.

Encourage the student not to major in an area in which he/she is weak (e.g. a student who is weak in math might not want to be a business major)

Make sure that **students know what resources are available** on campus and encourage them to seek help they need (learning lab., the OSD, professors themselves, other students, etc.). If you don't know an answer, or if the question is asked outside your area of expertise, refer students to the proper professional. Tell students what they need to know, but also, write down important information or give them the information in the form of a brochure.

What might be best for one person might not be best for another. Emphasize to students the fact **that each person is different**, and what is appropriate for their friends, might no be the best thing for them.

Recommend that students take **the College Success Skills (SLS 1101) and/or intro to Psych.: Special emphasis (SLS 1211)** course. This is a smart start for most of them.

Examine your own attitude. How do you feel about people with disabilities? Recognize your prejudices and work on overcoming them.

LIST OF PSYCHOLOGISTS IN BREVARD COUNTY
WHO EVALUATE ADULTS FOR ADHD AND LD

**** ALL QUOTES ARE APPROXIMATE AND DEPEND ON THE INITIAL EVALUATION AND TYPE OF TESTING NEEDED.***

A1A Institute for Family Counseling
1680 Highway A1A, Suite 5
Satellite Beach, FL 32937
Ph. 773-5944

Suzanne Sobel, Ph.D.

Specialty in ADHD, LD, stress management and counseling.
Fee: $125 per hr. Insurance accepted.

Associates in Psychiatry for Brevard, P.A.
1022 Florida Ave.
Rockledge, FL 32955
Ph. 632-7920

Kristopher Olsen, Ph.D.
Joel D. Shuy, Psy.D.
Thomas Peake, Ph.D.

Fee: $125 per hr.

(Depends on testing needed. Fees can be negotiated depending upon insurance**)**
($225 for basic 30-min. interview and testing for BCC students)
Insurance accepted if appropriate.

Associates in Psychiatry for Brevard, P.A.
1317 Oak St.
Melbourne, FL 32901
Ph. 951-1600

Thomas Peake, Ph.D.
Joel D. Shuy, Psy.D.

Specialty in ADHD and LD
Fee: $125 per hr.

Baker, Juanita Neal, Ph.D.
Florida Tech–Department of Psychology
150 W. University Blvd.
Melbourne, FL 32901
Ph. 674-8104

Specialty in LD and ADD/ ADHD
Full child/adolescent psychological assessment.
Fee: $129 per hr.

Bernstein, Howard R., Ph.D.
2235 N. Courtenay Pkwy., Suite A
Merritt Island, FL 32953
Ph. 459-1003

Does only testing.
Fee: $125 per hr. with $250 min.

Burnham Woods Counseling Centers of Florida, Inc.
Mariners Square
96 Willard St., Suite 101.
Cocoa, FL 32922
Ph. 639-4483

Fee: $125 per hr. with 1-2 hrs.

Burnham Woods Counseling Centers of Florida, Inc.
117 S. Park Ave.
Titusville, FL 32796
Ph. 639-4483

Nancy MacKay, Psy.D.
Medea L. Woods, Psy.D.

Specialty in LD and ADHD evaluations. Counseling to address dealing with ADHD.

Warner Connick, Psy.D.

State licensed teacher, counselor and school psychologist with experience in LD, exceptional education, intelligence assessment and ADHD.

Janet L. Helfand, Ph.D.

Fee: $110 per hr.
Counseling also available. Special rates for BCC students will be considered. Insurance considered. ADD/ADHD evaluations as well as evaluations for other disorders. Teaching effective coping skills also **a**vailable.

Community Psychological Services
Florida Tech
150 W. University Ave.
Melbourne, FL 32901
Ph. 727-9956

Specialty in ADD/ ADHD and LD and full psychological assessments.
Fee: varies with type of testing needed:
$150 for intellectual assessment.
$250+/- for ADD and LD.
Sliding fee scale.

Guidera, Thomas F., Ph.D.
1777 Garden St.
Titusville, FL 32796
Ph. 268-5682

Specialty in LD and counseling.

Krishnamurthy, Radhika, Psy.D.
150 W. University Blvd.
Melbourne, FL 32901
Ph. 674-8104

Specialty in ADD/ADHD and LD.
Full child/adolescent psychological assessment.
Fee: $120 per hr.

Lusk, Roy H., Psy.D.
1900 S. Harbour City Blvd., Suite 236
Melbourne, FL 32901
Ph. 724-8868

Specialty in ADHD and LD.
Fee: $125 per hr.

Mallams, John H., Ph.D.
6767 N. Wickham Rd.
Melbourne, FL 32940
Ph. 255-3299

Specialty in ADHD and LD.
Fee: $100 per session. Discounts based on ability to pay. Insurance and Medicare accepted

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Paulillo, Barbara M., Psy.D.
520 E. Strawbridge Ave.
Melbourne, FL 32901
Ph. 951-2010

Specialty in LD and ADD/ADHD.

Rainwater, Giles D. Ph.D. P.A.
2210 S. Front St., Suite 208
Melbourne, FL 32901
Ph. 729-0080

Specialty in ADD/ADHD. Stress management and neuropsychological testing.
Fee: $130 per hr. Insurance accepted

Seifer, Ronald L., Ph.D.
5240 Babcock St.,N.E., Suite 307
Melbourne, FL 32901
Ph. 724-1614

Specialty in ADD/ADHD, LD and counseling.
Insurance filed.
Fee: $130/initial consultation.
$130 per hr. for testing.

Seifer, Ronald L.,Ph.D.
1351 Bedford Dr**.** Suite 103
Melbourne, FL 32940
Ph. 757-6799

Specialty in ADD/ADHD, LD and counseling.

Fee: $130/ initial consultation.
$130 per hr. for testing.
Insurance filed.

Stevens, Charles Psy.D. P.A.
1980 N. Atlantic Avenue
Cocoa Beach, FL 32931
Ph. 784-1068

Fee: $350 for test battery.
Specialty in ADD/ADHD as well as autism.

Williamson, Jeffrey M., Ph.D.
2235 N. Courtenay Pkwy.
Merritt Island, FL 32953
Ph. 459-1003

Fee: $125 per hr. with $250 min.
Will test, but mainly works with children.
Neuropsychological consultation available.

Mental Illness in the Classroom

There are many types of mental illnesses including anxiety disorders (Panic Disorder, Post-Traumatic Stress Disorder, Obsessive-Compulsive Disorder, Social Phobia), personality disorders, bipolar disorders, schizophrenia, and others; therefore, it is difficult to generalize behaviors resulting from them. Considered to be physical brain afflictions, they disrupt a student's ability to think, feel, and relate to others. According to the National Alliance for the Mentally Ill, mental illness is more common than cancer, heart disease, or diabetes, and more than five million Americans suffer from an acute episode of mental illness each year.

Students with psychological difficulties are often a challenge to faculty because the disability itself may be invisible and because their behavior may range from disruptiveness to indifference. Some conditions may be temporary while others are chronic, and the behaviors that are manifested in class can be quite varied. Symptoms that mental illness might be present are: delusions, hallucinations, cognitive deficits, blunted affect, poverty of speech, anhedonia, apathy, increased motor activity, or elevated mood. Depression is one of the most common mental disorders in which a student may present the following: an appearance of apathy, disinterest, inattention, impaired concentration, irritability, or fatigue. Anxiety is also a prevalent condition on the college campus and may fall within normal limits and actually assist in the learning process. However, in its severe form, it can adversely affect learning by reducing the ability to concentrate and by distorting perceptions. It may be manifested by constant talking, complaining, joking, crying, extreme fear, panic, or withdrawal, and the student may experience lightheadedness, heart palpitations, and/or hyperventilation. In addition to the many psychological disorders from which students may suffer, they may also be affected by side effects from the medications that are prescribed for these conditions. A result of mental illnesses in the college setting may be inadequate performance of class assignments and inappropriate classroom behavior. It is important to remember that students with these disorders have little control over their disabilities.

The rules, laws, and responsibilities for students with psychological disabilities are the same as those that pertain to students with other types of disabilities. However, if a student is manifesting behavior that is affecting classroom management, the following suggestions may be considered:

1. Speak with the student privately about his/her inappropriate conduct. Clearly state the boundaries of acceptable behavior in your class. It may be appropriate to have a witness to your conversation.
2. Only speak about the student's behavior in your class. Do not attempt to counsel, treat, or diagnose.
3. If threatening behavior occurs, depending upon the severity, refer the student to the Dean of Student Development, call Security, or dial 911.

4. If the student is registered with the Office for Students with Disabilities (OSD), the student may be sent to that office. If it is not known if the student is registered with the OSD, that office may be called, and if the student has signed a release, the personnel there might be able to discuss the case and provide suggestions.

5. According to Circles of Care, one should use the following strategies for managing conflict:

A. Avoid blaming
B. Speak in a calm voice
C. Use clear, short statements to highlight the main points
D. Elicit the student's point of view
E. Focus on specific behaviors

6. Utilize the attached tips by Circles of Care for Responding to a Crisis, and Effective Communications in Crises.

7. If the student is requesting assistance, he/she may be referred to one of the following community resources:

A. Circles of Care Intake Services (24 hours) - 722-5257
B. Crisis Services of Brevard - 631-8944 or 211 (24 hours)

RESPONDING TO A CRISIS

During an intervention, your safety is a major consideration. The possibility of injury exists regardless of your background, experience, and relationship with the parties in crisis. For that reason, remember the following safety procedures:

1. If possible, always intervene with a partner. This is especially true when there is more than one person in crisis.
2. Approach the crisis or potential crisis slowly and carefully. Tae time to survey the surroundings for clues that might help later. Although time is critical, the precautions you take at the outset may prevent problems later.
3. Observe the person(s) in crisis. What are they doing? What must you do immediately to stabilize the situation? Do it!
4. Note any objects in the room that could be used in a violent way. A heavy ashtray or an innocent pencil could become a lethal weapon in the hands of a violent person.
5. Be aware of all other persons in the room, and note all persons who enter after you arrive. Assume nothing. Observe both the verbal and nonverbal behavior of everyone in the room.
6. Be prepared for unexpected behavior of significant others in the immediate area.
7. Initially step into the area or room only a few feet at a time. Proceed only as far as it seems safe.
8. If possible, have the person sit down. The potential for violence seems to be lower when everyone is seated.
9. Know where the entrances and exits are. Select an appropriate place to sit so you can be safe.
10. Sit in the following manner: feet solidly on the floor with heels and toes touching the floor; hands unfolded on your lap; your body leaning slightly forward toward the person. This position accomplishes two important functions:
    - It gives the person the feeling that you are attentive to hat is being said and experienced. Your body language conveys a sense of interest and concern.
    - It permits you to respond immediately should you be physically threatened. Although crossed-leg, folded-arm position, or a similarly relaxed position may be comfortable, it can reduce you ability to respond quickly should an immediate response be needed.
11. Attempt to speak with the person at eye level.
12. Avoid standing above the person in an authoritarian or parental manner. If the person chooses to remain standing, you should remain standing too.
13. Do not turn your back on the person or allow the person to walk behind you.
14. Do not position yourself in a corner from which you cannot exit.
15. Stand in the following manner: feet placed shoulder-width apart; one foot slightly behind the other; weight on the rear leg; knees slightly bent; hands folded, but not interlocked, on the upper abdomen or lower chest; arms unfolded. This unrestricted stance permits instant response to a physical threat. Hands placed in one’s pockets are suspect, and having to remove your hands increases your response time. Folded arms can be threatening and can impede your response. Maintaining your weight on the rear leg with knees slightly bent permits quick movement in almost any direction without affecting balance.

BREVARD COMMUNITY COLLEGE SUBSTITUTION POLICIES CONCERNING STATE BOARD OF EDUCATION RULE 6A-10.041 FLORIDA STATUTES 240.152 and 240.153 FOR ELIGIBLE STUDENTS WITH DISABILITIES

Any student who has a documented hearing impairment, visual impairment, specific learning disability, or other disability as designated by law and defined by Rule 6A-10.041 shall be eligible for reasonable substitution(s) of any requirement for admission to the College, admission to a program of study, or graduation from the College provided that:

1. the disability can reasonably be expected to prevent the student from meeting the necessary requirements; and
2. the failure to meet the requirement(s) does not constitute a fundamental alteration in the nature of the program.

PROCEDURE

I. A mechanism to identify eligible persons for reasonable substitutions - Students must provide documentation of a disability written by a qualified professional to their campus Office for Students with Disabilities (OSD). The documentation must verify that the disability substantially limits one or more major life activity, and will be reviewed by the Director of the OSD for compliance with federal legislation and Florida Statute guidelines.

II. A mechanism for identifying reasonable substitutions for admissions to the College, to a program of study, or for graduation from the College – All requests for substitutions will be considered on an individual basis.

A. **Reasonable substitution for criteria for admission to the institution**

1. BCC is committed to equal educational opportunities for all students and thus, does not discriminate on the basis of race, color, sex, age, national origin, or disability in its admission and treatment of students. The College has an Open Door policy and having a disability does not prevent a student from being admitted. However, should a student, because of a

documented disability, not meet admissions requirements, the student should act in accordance with the following procedure:

a. He/she should present appropriate documentation of the disability to the Campus Disability Services Specialist or designee who, on behalf of the student, will file a request for substitution for criteria for admission to the College.

b. The Disability Services Specialist or designee will work with the Director of the OSD to recommend a reasonable substitution for criteria for admission to the College to the appropriate campus Dean of Educational Services.

c. The Campus Dean of Educational Services will approve or deny the recommendations for substitution.

B. **Reasonable substitution for criteria for admission to a program of study**

1. Certain programs within the College have specific entrance requirements. To apply for reasonable substitution(s) for these requirements,
the student should act in accordance with the following procedure:

a. He/she should present appropriate documentation of the disability to the Campus Disability Services Specialist or designee who, on behalf of the student, will file a request for substitution for criteria for admission to the program of study.

b. The Disability Services Specialist or designee will work with the Director of the OSD to recommend a reasonable substitution for specific criteria for admission to the program, to the appropriate Department Chairperson.

c. The Department Chairperson will approve or deny the recommendations for substitution.

C. **Reasonable substitutions for criteria for graduation**

1. A student whose disability impacts his/her ability to complete one or more graduation requirement may apply for such things as course substitutions and waivers of the CLAST by acting in accordance with the following procedure:

a. He/she should present appropriate documentation of the disability to the Campus Disability Services Specialist or designee who, on behalf of the student, will file a request for substitution for criteria for criteria for graduation.

b. The Disability Services Specialist or designee will work with the Director of the OSD to recommend a reasonable substitution for criteria for graduation from the College to the appropriate Campus Dean of Educational Services.

c. The Campus Dean of Educational Services will forward the recommendation(s) to the Associate Vice President for Educational Services who shall chair and convene a committee to approve or deny the request. The committee shall be comprised of the following people:

Appropriate Campus President
Appropriate Campus Dean of Educational Services
Director of the Office for Students with Disabilities

III. A mechanism for making the designated substitutions known to the affected persons

A. Students requesting substitutions will be contacted personally by the Director of the Office for Students with Disabilities or the Campus Dean of Student Development and will be advised as to the outcome of the request. If the requested substitution(s) has been granted, the Collegewide Director of Admissions/Records will also be notified.

IV. A mechanism for appeal of a denial of a substitution request or to appeal a determination of ineligibility

A. The student should file a written appeal to the Campus Disability Services Specialist or designee. This appeal shall be forwarded to the Director of the Office for Students with Disabilities. The appeal shall be presented to a committee consisting of the following people:

Associate Vice President for Educational Services
Campus President
Campus Dean of Educational Services
Equity Coordinator
A representative from an appropriate community agency who is knowledgeable of the specific disability or impairment
Director of the Office for Students with Disabilities

The Associate Vice President for Educational Services and the Director of the Office for Students with Disabilities are members of the Appeals Committee as resource members only and cannot vote. The committee will forward its recommendation(s) to the District President whose decision is final.

V. A mechanism for record keeping

A. Records shall be maintained on the number of students with disabilities requesting, granted, and denied substitutions. The Director of the Office for Students with Disabilities will maintain these records.

VI. A mechanism for articulation with other state institutions

A. The College will accept all substitutions previously granted by other state post-secondary

institutions and/or institutions with which the College has articulation agreements as they may relate to admission to the College, a program of study, or graduation from the College.

B. When granting substitutions, the College will consider whether the substitutions that it provides will be accepted by the receiving institutions, and advise its students accordingly.

VII. A mechanism for notifying students regarding the substitution procedure

A. Information will be included in the student handbook, college catalog, and other college publications.

BREVARD COMMUNITY COLLEGE
OFFICE FOR STUDENTS WITH DISABILITIES (OSD)
POLICIES AND PROCEDURES

Welcome to the Office for Students with Disabilities! It is our aim to assist you in your academic pursuits so that you are successful in reaching your educational goals.

Provide Documentation

1. To register with the OSD, you must complete several forms and provide documentation of your disability. The documentation must be from a qualified health professional or agency, and it must verify the presence of an impairment that substantially limits a major life activity or function.

List Accommodations

2. On the Intake Form, list those accommodations you are requesting. They will be approved by the director on an individual basis according to the documented disability. If you need any type of adaptive furniture, software, equipment, or an interpreter, make sure to notify the OSD prior to the beginning of classes each semester.

Notify Instructors

3. The OSD keeps all information confidential. If you choose to notify your instructors of your disability, you may request a Teacher Notification Form from the OSD. It is your responsibility to talk with your instructor about your disability and give him/her the form.

Plan Ahead for Classroom Tests

4. A. For each test, remind your professor beforehand to send it to the OSD
   B. Make an appointment with one of the staff people in the OSD for each test you plan on taking there
   C. Tests must be taken at the same time they are given in the classroom unless prior arrangements are made with the instructor
   D. Cheating will not be tolerated in the OSD. While taking a test, you must remain in the OSD until it is completed. Tests will be proctored in person or by monitor. If you are caught cheating, the test will

immediately be taken away and returned to the faculty member who will decide on sanctions. Any document that is used during a test will be returned with the test to the instructor.

Get Help Early

5. If you are not doing well in a class, after speaking with your instructor, contact the OSD for assistance.

Keep Tutoring Appointments

6. It is your responsibility to make appointments for tutoring if this is available on your campus. If you have an emergency and need to miss your appointment, you are to immediately notify the OSD. After three missed appointments, your time slot will be given to other students.

Follow Code of Conduct

7. All students are expected to abide by the BCC Code of Conduct. Physical, verbal or psychological abuse is not acceptable in the OSD and will be reported to the proper authorities.

Teacher Notification Forms

8. Teacher notification forms listing your approved accommodations may be given to you or mailed to your instructors. It is necessary to request these **each semester**.

Other Campus OSD Rules

9. Each campus OSD may have additional rules; make sure that you read and understand them in addition to the ones above.

I have read (or had read to me), understand, and have received a copy of these policies and procedures.

Signature Date

Brevard Community College
Office for Students with Disabilities
Teacher Notification Form

MEMORANDUM

To: Faculty

From: Lyndi K. Fertel, Ph.D., Office for Students with Disabilities

Date: _____

Subject: _____ _____
Name SS #

_____
Class

The aforementioned student has self-identified as a student with a disability and has provided the Office for Students with Disabilities with appropriate documentation of his/her disabling condition(s). Students with disabilities are entitled by law to reasonable accommodations that will provide them with equal opportunities for success in their academic program(s). Approved accommodations for this student are initialed below. If you have any questions, please feel free to telephone me at extension 63607.

1. _____ extra time on tests
   _____ 50%; _____ double; _____ unlimited; _____ other
2. _____ individual testing in a quiet room (available in the OSD)
3. _____ use of books on tape/large print texts
4. _____ use of a magnifier in class
5. _____ use of sign language interpreter
6. _____ will lip read in class
7. _____ preferential seating in class
8. _____ use of adaptive furniture in class (special table/chair)
9. _____ accommodation for spelling errors in grading
10. ____ allowance of dictionary/spell check during class and tests
11. ____ note taker service
12. ____ oral testing
13. ____ allowance of tape recorder in classes
14. ____ use of calculator for tests
15. ____ not to be singled out in class
16. ____ copy of syllabus/assignments provided in advance
17. ____ reduced course load
18. ____ other _____

_____

Thank you for your cooperation. 6/01

Brevard Community College
Office for Students with Disabilities
****Student Authorization for *Release of Information*****

I, _____ give permission for the
Student's Name (Print)

Office for Students with Disabilities to share with members of the **administration and/or faculty**, any diagnostic and/or instructional information pertaining to me for the purpose of assisting me in my studies and coursework. I also give permission for the staff to release information to the following outside agencies/persons: *(Initial or Cross Out)*

_____ Vocational Rehabilitation

_____ Division of Blind Services

_____ Worker's Compensation

_____ Other _____
(Name of Agency or Person)

_____
Student's Signature

_____
Student Number

_____
Date

_____
Witness

* If any restrictions apply to the authorization, please list them below

_____

_____ _____

6/01

Office for Students with Disabilities
Documentation Guidelines

Welcome to the Office for Students with Disabilities (OSD). It is the mission of our office to furnish the support services and devices necessary for all students with disabilities to achieve their educational goals.

To be eligible for accommodation(s) through the OSD, each student must satisfy the definition of a disability as established by the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973. Section 504 defines a disability as a condition which substantially limits one or more of the major life activities such as walking, seeing, hearing, breathing, learning, caring for oneself, working, and several others. ***To be eligible for services through the OSD, students must provide appropriate documentation of the disability that demonstrates an accompanying substantial limitation to one or more major life activity.***

It is the responsibility of the **student** to bring documentation of the disability to the OSD. The documentation must be submitted before any services/devices can be provided. This documentation must meet certain **guidelines**:

(1) Documentation should be written on **letterhead** stationery and include the **diagnostician's name, title, professional credentials, date, and signature.** Notes on prescription pads will not be accepted.

(2) The professionals conducting the assessment or certifying the diagnosis must be **qualified** to do so.

(3) The specific diagnosis of the disability must be **clearly stated** and explained, not vague or inconclusive. For example a DSM IV diagnosis should be provided for any mental illness; visual acuity should be provided for a visual impairment; an audiologic report should be provided for a hearing impairment; and a comprehensive psychological evaluation and achievement testing should be included to document learning disabilities.

(4) The report should address the degree of **current functional loss and/or limitation(s)** of the disability. It should state the current symptoms of the disorder, and include anticipated effects of the limitations within an academic setting.

(5) If possible, the documentation should include **suggested accommodation(s) and/or auxiliary aid(s)** for the student.

(6) If **medication**(s) are taken, these should be listed, as well as their potential side effects.

(7) The documentation should be from within the last **three** years. However, the OSD reserves the right to make modifications to this time frame or any of the above guidelines, on an individual basis.

Brevard Community College
Office for Students with Disabilities
Intake Form

Name: _____ Date: _____ E-mail Address: _____

Soc. Sec. (Student I.D.) Number: _____ Telephone # : _____

Local Address: _____ Permanent Address: _____

_____ _____

Program of Study: _____ *Nature of Primary Disability/Handicap: _____

If you have a disability, you may be eligible for certain reasonable accommodations. To receive these accommodations, you are asked to provide more specific information by completing the remainder of this form. Letters of verification can be obtained from individuals such as attending physicians, learning disabilities specialists, counselors from the Division of Blind Services, the Office of Vocational Rehabilitation and the Veteran's Administration.

Accommodations

As a student with a disability, are you in need of specific equipment/furniture to assist you in continuing your education? _____yes _____no. If yes, please specify: _____
_____
_____

As a student with a disability, are you requesting special accommodations in order to enable you to continue your education? ____yes ____no. Accommodations requested: (your documentation must support your request).
_____
_____

Agencies of which you are a client (e.g. Division of Blind Services, Office of Vocational Rehabilitation, Veteran's Administration, etc):

1. Agency Name: _____ Address: _____
   Counselor Name: _____ Phone: _____ Date: _____
   Comments: _____

2. Agency Name: _____ Address: _____
   Counselor Name: _____ Phone: _____ Date: _____
   Comments: _____

Certification

Auxiliary learning aid assistance requested is not available to me from any state or federal program responsible for such assistance. If currently a client of another agency, I will inform this office if financial benefits for auxiliary aids are changed, and in any event I will contact or authorize permission to be referred to another appropriate agency for possible sponsorship and will inform this office of the results of the meeting.

Approved Accommodations:_____
_____
_____
_____

_____ _____
Student Signature *Authorized Signature*

*Note: See reverse side for description of disabilities/handicaps.

Nature of Disability

In order to provide accommodations to students with disabilities, BCC is asking for voluntary self-identification of students with a specific disability. This information will be kept confidential and will be used for the purpose of aiding you, the student, to achieve your fullest potential while enrolled in postsecondary education.

*Please indicate with a "**P**", your primary disability, and an "**S**" for other disabilities.

( ) **Visual Impairment**: Disorders in the structure and function of the eye as manifested by at least one of the following: 1) visual acuity of 20/70 or less in the better eye after the best possible correction 2) a peripheral field so constricted that it affects one's ability to function in an educational setting 3) a progressive loss of vision which may not affect one's ability to function in an educational setting. Examples include but are not limited to the following: cataracts, glaucoma, nystagmus, retina detachment, retinitis pigmentosa, and strabismus.

( ) **Hearing Impairment**: A hearing loss of 30 decibels or greater, pure tone average of 500, 1000, 2000 Hz, ANSI, unaided, in the better ear. Examples include but are not limited to the following: conductive hearing impairment or deafness, sensorineural hearing impairment or deafness, high or low tone hearing loss or deafness, acoustic trauma hearing loss or deafness.

( ) **Physical Impairment**: (Musculoskeletal and connective tissue disorders, neuromuscular disorders). Physically disabling conditions which may require an adaptation to one's school environment or curriculum. Examples include but are not limited to the following: cerebral palsy, absence of a body member, clubfoot, nerve damage to the hand and arm, speech, Cardiovascular Aneurysm (CVA) or head injury and spinal cord injury.

( ) **Specific Learning Disabilities**: A disorder in one or more of the basic psychological or neurological processes involved in understanding or in using spoken or written language. Disorders may be manifested in listening, thinking, reading, writing, spelling, or performing arithmetic calculations. Examples include dyslexia, dysgraphia, dysphasia, dyscalculia, and other specific learning disabilities in the basic psychological or neurological process. Such disorders do not include learning problems which are due primarily to visual, hearing, or motor handicaps, to mental retardation, to emotional disturbance, or to an environmental deprivation.

( ) **Other Impairments** (Please specify any other conditions that require an administrative or academic adjustment such as class schedules, parking and course adjustment and do not fit into any of the above categories, such as ADHD, psychiatric disorders, etc):

_____

_____

_____

OFFICE FOR STUDENTS WITH DISABILITIES
BREVARD COMMUNITY COLLEGE
LEARNING NEEDS ASSESSMENT – INTAKE FORM

NAME:_____ **DATE:**_____
ADDRESS:_____ **SS#** _____
_____ **DATE OF BIRTH** _____
HOME PHONE:_____ **AGE:** _____
WORK PHONE:_____
E-MAIL:_____
EMERGENCY PHONE # :_____ **Relationship to you :** _____
PROPOSED MAJOR: AA_____ **AS**_____ **CERTIFICATE**_____

**** All responses are voluntary and all information will be kept confidential ****

I. MEDICAL HISTORY

1. Do you have problems with any of the following?
(Check those that apply to you)

	YES	DATE 1st OCCURRED?	COMMENTS: (Are you currently being treated by someone for this? Dr.'s name. Does your condition impact your learning in any way? How?)
hearing	____	_____	_____
vision	____	_____	_____
allergies	____	_____	_____
asthma	____	_____	_____
diabetes	____	_____	_____
epilepsy	____	_____	_____
emotional	____	_____	_____

head injury ____ _____ _____

_____

Learning
disability ____ _____ _____

_____

_____

ADD/
ADHD ____ _____ _____

_____

other ____ _____ _____

_____

Are you currently taking any
medications on a regular basis? YES_____NO_____ IF SO , WHAT? _____

_____

II. FAMILY & SOCIAL

1. Marital Status: Single _____ Married_____
   Divorced _____ Widowed_____

2. How many people presently live in your household? _____relationship_____

   _____

3. How would you rate your support system? _____

   _____

4. Did either your mother or father complete a 4 year college degree? _____

5. Are you presently employed? _____ Where?_____Hours_____

7. Have you ever received financial aid for college?_____ Are you receiving aid now?_____

6. Are you the main provider of financial support?_____

   _____

8. Are you presently working with: VOC REHAB?_____ VETERANS ADMIN?_____
   DIVISION OF BLIND SERVICES?_____ OTHER?_____

9. Did you ever live outside of the U.S.?_____Explain_____

   _____

III. PSYCHOSOCIAL HISTORY

1. Do you ever suffer from test anxiety? _____

   _____

2. Have you ever gone blank on a test?_____

3. Have you ever been on medications for psychological reasons? (example: depression, anxiety)_____

   Explain:_____

   _____

4. Have you ever had a severe head injury?_____If yes at what age?_____Were you hospitalized?_____

   Explain:_____

   _____

5. Did you have problems in school before the injury?_____

6. Have you ever been told by a teacher that:
   - you are not doing your best_____
   - you would do better if you just studied_____
   - you would do better if you were more organized_____
   - you would do better if you could sit still_____

IV. ACADEMIC HISTORY

1. Did you get a High School diploma?_____Type?_____or G.E.D._____When?_____

2. What was your best subject in school?_____

   What was your worst subject in school?_____

3. Were you ever in any Special Education classes in school? Yes_____ No_____ What type?_____
   Learning disabilities _____

   ADD/ADHD _____

   Gifted_____

   Other_____

4. Did you ever receive any other type of special help in school?
   Remedial reading?_____Tutors?_____

   Counseling?_____ Other? _____

5. Has anyone in your family ever been diagnosed with a learning disability?_____Who?_____

V. GOALS

1. How many hours are you currently enrolled in?_____ How many college credits do you have?_____

   Have you ever attended another college or some other type of post-secondary institution_____

   _____

2. What are your career goals?_____

   _____

   _____

   _____

3. What extra services do you believe would help you in your academic pursuit?_____

   _____

   _____

   _____

VI. PRESENTING LEARNING PROBLEMS

1. What brought you into our office?_____

   _____

2. Is there a subject with which you are currently experiencing trouble?_____

   _____

3. Is attendance or assignment completion a problem for you?_____

   _____

4. How does your disability impact your everyday life?_____

   _____

   _____

   _____

ADDITIONAL INFORMATION: _____

_____

_____

_____

Brevard Community College
Office for Students with Disabilities Cheating Policy

The Office for Students with Disabilities on every campus will not tolerate cheating and/or academic dishonesty in any form. If anyone is caught cheating on a test or examination, that test/examination will immediately be taken away from the student and returned to the student's instructor. Any other type of academic dishonesty will be reported to the instructor to be dealt with by that particular faculty member. The Brevard Community College Catalog contains a section pertaining to the Student Code of Conduct and Academic Dishonesty Cases. The same policy will be followed with cases of students who have disabilities as with any other student.

I understand the statement above and pledge not to commit any form of academic dishonesty while in the Office for Students with Disabilities.

–

Print Name Date

Signature Social Security Number

Brevard Community College
Office for Students with Disabilities
Tutorial Agreement

The Office for Students with Disabilities provides tutoring in mathematics and English, by appointment. Students are expected to report for their scheduled appointments on time and prepared. If a student cannot report for his/her scheduled appointment because of an emergency, he/she is expected to call the Office for Students with Disabilities in advance, to cancel. If he/she fails to call, this will be counted as a missed appointment. If a student misses three or more scheduled appointments in a row, he/she will forfeit his/her time slot and it will be assigned to another student.

I, _____ have read the above rules and
Print name
agree to abide by them.

_____ _____
Signature date

Appointments scheduled: _____

_____

Appointments missed: _____

_____

Appointments cancelled: _____

_____

Semester: _____

BREVARD COMMUNITY COLLEGE
Waiver of TABE Scores for Students with Documented Disabilities

1. TABE score waivers will only be considered after remediation and second administration of the test.
2. The student must provide proper documentation of his/her disability for waiver of TABE scores consideration.
3. The student should submit this completed form to the campus Office for Students with Disabilities or mail to: Dr. Lyndi K. Fertel, Office for Students with Disabilities, 1519 Clearlake Rd., Cocoa, FL 32922.

Per State Board Rule 6A-10.040, Section 4, I am applying for a waiver from meeting the vocational basic skills levels.

_____ _____-_____-_____ _____

Print Name | Social Security Number | Telephone Number

_____

Street Address | City | Zip

Program/Major: _____

Chairperson/Instructor: _____

Reason for waiver request: _____

(type of disability)

Documentation: (check those that apply)

_____ On file in Office for Students with Disabilities on the following campus:

Cocoa _____ Melbourne _____ Titusville _____ Palm Bay _____

_____ Attached

_____ Will mail (to: Dr. Lyndi K. Fertel, Office for Students with Disabilities, 1519 Clearlake Rd., Cocoa, FL 32922)

Expected Program Completion Date: _____

_____ _____

Signature | Date

For Office Use Only

Instructor's Comments: _____

TABE test dates: (1) _____ (2) _____

Documentation Received: _____

Granted (date)_____ Denied (date) _____ Computer input (date) _____

Comments: _____

Office for Students with Disabilities (OSD)
EMPLOYEE STATEMENT OF CONFIDENTIALITY

I understand that by the virtue of my work in the Office for Students with Disabilities at Brevard Community College, I may have access to confidential records, files, and information regarding students with disabilities. I recognize that the disclosure of this information without a student's consent is a violation of law and carries both civil and criminal penalties. Disclosure includes the identification to outside individuals of any students utilizing services in the OSD.

I therefore pledge to preserve the privacy of students utilizing the OSD and not to reveal any confidential information seen or heard in this office.

_____

_____

Signature Date

DISABILITY CATEGORIES & REASONABLE ACCOMMODATIONS

(from "Handbook for Provision of Services for Students with Disabilities in the Florida Community College System")

In all categories, maintaining student confidentiality and privacy is essential

Hearing Impairment/Deafness: a hearing loss of thirty (30) decibels or greater, pure tone average of 500, 1000, 2000 Hz, ANSI, unaided, in the better ear. Examples include, but are not limited to, conductive hearing impairment or deafness, sensorineural hearing impairment or deafness, high or low tone hearing loss or deafness, acoustic trauma hearing loss or deafness.

Reasonable Accommodations

- front row seating is advisable
- if an interpreter is used, the student's view should include the interpreter and the instructor
- the instructor's face should be within view of the student, with speech in natural tone, no exaggeration of lip movement, and no shouting
- when using an interpreter, one should speak directly to the student and not to the interpreter
- visual aids and the chalkboard should be used to reinforce spoken presentations, when possible
- if requested, one should assist the student in identifying a note-taker
- when possible, one should provide the student with class outlines, lecture notes, lists of new technical terms and printed transcripts of audio and audio-visual materials
- regular written communication with the student is advisable
- if the instructor is in front of a light source, (e.g., window) the student may experience difficulty reading lips
- assistive listening devices should be made available to the students
- instructors should encourage students to self-disclose in all categories, the disability relevant to varying instructional modalities
- rooms should remain partially lit when using audio-visual materials
- maintaining student confidentiality and privacy is essential

Visual Impairment/Blindness: disorders in the structure and function of the eye as manifested by at least one of the following: visual acuity of 20/70 or less in the better eye after the best possible correction, or a peripheral field so constricted that it affects one's ability to function in an educational setting. Examples include, but are not limited to, cataracts, glaucoma, nystagmus, retinal detachment, retinitis pigmentosa, and strabismus.

Reasonable Accommodations

- one should provide information regarding Recordings for the Blind and Dyslexic
- one should provide written materials as early as possible
- one should consider using materials which enable students to use touch or the tactile modality
- instructors should allow students to use tape recorders in class
- readers should be provided as necessary
- one should be encouraged to provide general aids to persons who are visually impaired such as magnifiers, Braille, large print, large print generating software, voice synthesizers, etc.
- instructors should describe the physical arrangement of the classroom and never change this arrangement without informing the student
- one should orient the student to the location of restrooms and other important places on the campus
- instructors should verbalize while writing on the board
- where relevant to instruction, one should attempt to orally explain what is communicated through body language
- low vision students benefit from front row seating
- in instructor should face the class when speaking
- large print copies of classroom materials should be provided
- alternate test formats (e.g., oral testing, additional time, tape recorded questions, reader) may be necessary

Psychological/Emotional Disorders: a specific condition with certain sets of symptoms which are defined in the *Diagnostic and Statistical Manual of Mental Disorders (DSM IV)*. This manual is used by psychiatrists for determining diagnosis, treatment, insurance, and medication coverage.

These disorders may be hidden or, in fact, latent. Examples include, but are not limited to, the following: Attention Deficit Hyperactivity Disorder (ADHD), schizophrenia, autism, anxiety disorders, memory disorders, personality disorders, depression, eating disorders post-traumatic stress disorder, substance dependence, etc.

Reasonable Accommodations

- extended time may be needed on classroom tests
- quiet, distraction free testing area
- discussion with the student regarding appropriate classroom behavior and expectations may be warranted
- referral to mental health provider may be necessary
- consistency with communication and interaction styles with students is recommended
- students should be encouraged to keep a routine

Speech Impairments: disorders of language, articulation, fluency, or voice which interfere with communication, pre-academic or academic learning, vocational training, or social adjustment. Examples include, but are not limited to, the following: cleft lip and/or palate with speech impairment, stammering, stuttering, laryngectomy, or aphasia.

Reasonable Accommodations

- written speeches may be a possible alternative to oral presentations required in class
- provide the opportunity without compelling students to speak in class
- permit students the time required to express themselves without unsolicited aid in filling in gaps in their speech
- encourage students to repeat statements to provide clarity
- address students naturally
- a possible course substitution for the required speech class may be considered

Physical Impairments: This disability may be one with partial or total paralysis, amputation or severe injury, arthritis, active sickle cell disease, muscular dystrophy, multiple sclerosis, polio, cancer, AIDS, cerebral palsy, head injury, or spinal cord injury. This category may also

include such hidden disabilities as pulmonary disease, respiratory disorders, lupus, or epilepsy.

Reasonable Accommodations

- one should be familiar with the building's emergency evacuation plan and assure that it is manageable for students who are physically disabled
- the instructor should permit the use of a note-taker or tape recorder
- students with hand-function limitations may have difficulties both in the laboratory and in the classroom, doing in-class writing assignments and taking written tests
- instructors may give oral tests
- students may need a scribe/amanuensis
- students may need extended time on tests and/or assignments
- adaptive equipment/furniture may be requested and provided, where possible

Learning Disabilities: See Learning Disabilities section of binder

Learning Disabilities-Some Definitions

The federal government has defined learning disabilities in Public Law 92-142 (The Education of All Handicapped Children Act) and IDEA (Individuals with Disabilities Education Act) as follows:

"Specific learning disability means a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken, or written, which may manifest itself in an imperfect ability to listen, think, speak, write, spell, or to do mathematic calculations."

A learning disability (LD) is a life-long disorder, which affects the manner in which individuals with normal or above average intelligence select, retain, and express information. Incoming or outgoing information may become scrambled as it travels between the senses and the brain.

In adults, leaning disabilities are commonly recognized as deficits in one or more of the following academic areas:

- Comprehension
- Written expression
- Math computation
- Spelling
- Problems solving

Less frequent, but no less troublesome, are problems with organizational skills, time management, and social skills. Many adults with learning disabilities may also have language-based and /or perceptual processing problems.

Learning Disabilities and the College Student

The field of learning disabilities is a puzzlement because the students with learning disabilities usually have strengths which obscure their weaknesses. For example, they may not be able to write an essay, but are able to tell an interesting, detailed story or relate specific facts about a certain topic. They may not be able to follow simple directions, but are able to put together a complicated puzzle or model car. They may not be able to find their way around campus, but are able to rebuild an automobile engine or make an "A" on a psychology exam.

Persons who are able to perform well on some tasks, but poorly on others are said to have discrepancies in their learning abilities. (We all have such discrepancies, but it is a matter of degree). Such discrepancies may be observed when comparing their present performance, for example being unable to read at grade level even though they have average or above average intelligence. This predicament facing this person is referred to as a discrepancy between actual achievement (performance) and ability (often referred to as IQ).

Unlike physical disabilities, which are easily visible and relatively easy to diagnose, a learning disability is not obvious and is often complicated by adjustment problems.

While there is no definite conclusion about the major cause of learning disabilities, it is felt that people are not cured of this disability. They can learn to cope and to compensate in various degrees, but the learning weakness will always remain.

The point should also be emphasized that certain students with learning disabilities are so capable in some areas, that faculty sometimes misjudge their learning difficulties as being due to lack of motivation, emotional problems, laziness, etc. Obviously, this situation can be very frustrating for the student with a learning disability who is trying to learn the material in a course.

To summarize, the student with an LD displays a severe discrepancy between achievement and potential and exhibits a pattern of strengths and weaknesses within an intellectual range of average to above average.

Frequently Asked Questions

How should you approach a student you suspect has a learning disability?

- Take the student aside and explain that you have noticed that he/she has had difficulty with many of the concepts in the course. Suggest some services on campus that might be helpful to the student such as Student Support Services, the Learning Lab, or the Office for Students with Disabilities (OSD). The OSD provides testing for learning disabilities.

How do you administer tests to a student with a disability without embarrassing that student or calling attention to him or her?

- Any student working through the OSD has been instructed to speak with his/her instructor several days prior to the test and make arrangements. The instructor usually delivers the tests to the OSD. On the day and time of the test the student goes to the OSD rather than to class. Other arrangements should be made with the student, privately.

In my history class, one of the students working through your office, makes consistent spelling and grammatical errors on his papers. On the accommodation sheet (Teacher Notification Form) for the student, use of a word processor, spell check and use of an electronic spelling device are all checked. Shouldn't a college student be required to write a grammatically correct sentence in history or any other college course?

- Yes, and no. We would all like students to able to write papers that are correct. The truth is that many students cannot do that no matter how much they try or how many times they re-write the paper. The students who receive these accommodations have severe written language problems, called dysgraphia.

A student with a reading problem and who had an IEP (Individual Education Plan) in high school stating that she only had to do one-half of the vocabulary, has asked me to modify the curriculum. What should I do?

- You are not required to give any accommodation to any student that has not been approved through the OSD. Additionally, modifying the curriculum is an appropriate accommodation for a high school student under IDEA (Individuals with Disabilities Education Act), but is not appropriate for a college student under ADA (Americans with Disabilities Act).

Strategies for working with students with a Learning Disability

Many of the strategies effective for students with learning disabilities are those that would be effective for all students. Following are some suggestions:

Copy your syllabus onto colored paper so that students can locate it easily. Avoid crowding too much information on one sheet. Use lots of white spaces to avoid too much clutter on a page.

Refer to the syllabus at the beginning and end of each class. This helps students plan, organize and project when assignments, projects, and tests are to be completed.
Begin each class with a review of material covered in the previous class or classes. This helps with memory and starts everyone on the same page. Students with LD frequently have concomitant memory problems.

Use a chalkboard, overhead projector or a PowerPoint presentation to review major concepts from the previous classes. This provides students with a multi-modality approach as well as a review of major concepts.

Work practice problems in class, which represent those in the homework assignment. The function of homework is often to practice skills already taught.

Have weaker students sit in the front of the class. Typically, students with learning problems are very insecure about their abilities and tend to sit in the back of the room and be as inconspicuous as possible. By moving weaker students to the front, they get more actively involved in the presentation and exchange of information. In addition, the instructor can do closer error monitoring of the student's progress.

Use a variety of testing formats to assess mastery of a set of skills such as: essay, short answer, fill in the blank, true/false, and matching. To assess progress over an entire term, one can use portfolio assessment, projects, journaling, video presentation or other media technology and group work.

Break the class time into several components such as: review, lecture, group practice, and recap.

Remind students of additional help available for them in Learning Lab, Student Support Services, and the Office for Students with Disabilities.

Have examples of projects, term papers, and reports so that students can see a completed project. Some students work from the whole to the parts, while others work in the opposite manner.

Provide students with an outline of your lecture with spaces in-between lines so they can fill in the details. This helps students with organization as well as gives them a framework from which to build.

SOME OF THE CHARACTERISTIC LEARNING DIFFERENCES TO LOOK FOR IN ADULTS WITH LEARNING DISABILITIES

1. LEVEL OF WORK PRODUCTION VARIES
   A. Demonstrates marked difficulty in reading, writing, spelling and/or numerical concepts in contrast with average to superior skills in other areas.
   B. Has poorly formed handwriting – may print instead of using script; writes with inconsistent slant, has difficulty with certain letters, spaces words unevenly.
   C. Confuses similar letters such as "b" and "d", or similar words such as "sour" and "sore"; transposes words, numbers or letters; misuses or misspells easy words; uses the wrong tense of a word in a sentence causing the sentence to make no sense; bizarre spelling errors.
   D. Inconsistent performance on different skills, either in a single class time or from day today.
   E. Difficulty understanding and/or recalling basic mathematical concepts; difficulty remembering the multiplication tables; mixing up symbols in computations such as (+ for -); reversal of numbers, difficulty understanding word problems; fluid or abstract reasoning problems; can verbally explain how to do a problem but cannot do it on a test.
   F. Demonstrates knowledge in the classroom but not on tests.

2. QUICK LEARNER BUT QUICK FORGETTER
   A. Displays a significant disparity between oral language and vocabulary skills or written work and test scores.
   B. Short attention span.

3. DIFFICULTY UNDERSTANDING OR FOLLOWING DIRECTIONS
   A. Has trouble listening to a lecture and taking notes at the same time.
   B. Misunderstands what is expected on assignments and/or tests.
   C. Has trouble understanding or following directions; is easily overwhelmed by a multiplicity of directions or overstimulation; may not understand information the first time it is given; needs things repeated often.

4. LOSES TIME AND/OR FUTURE DOES NOT EXIST
   A. Seems disorientated in time; is often late to class; is often unable to finish assignments within a given period of time.
   B. Takes an excessive amount of time to finish classroom assignments or homework.

5. ORGANIZATIONAL DIFFICULTIES
   A. Difficulty copying from the board or textbook.
   B. Is easily distracted by background noise or visual stimulation; is unable to pay attention; may appear to be anxious or hurried.
   C. Exhibits an inability to stick to simple schedules; repeatedly forgets things; loses

The OSD Newsletter
(Office for Students with Disabilities)
March, 1999 (1)

This is the first issue of the Office for Students with Disabilities monthly newsletter, a short, informational communication pertaining to disabilities. Please feel free to submit comments, questions, and/or constructive criticism.

What do the following people have in common?
JFK, Cher, Tom Cruise, Albert Einstein, Nelson Rockefeller, Winston Churchill, Hans Christian Andersen, Agatha Christie, Henry Ford, Auguste Rodin, Thomas Edison, Leonardo da Vinci, Friedrick Nietzsche, Ludwig van Beethoven

They all have learning disabilities!!!

People with learning disabilities comprise the largest percentage of any one disability being served by the OSD (approx. 40%+ of all of our students). This "invisible" disability is also one of the most misunderstood. For these students the OSD provides services including the administration of placement and classroom tests with additional time provided; academic advisement and priority registration; some tutorial services; and tips on how to better manage their disabilities.

In order to be characterized as learning disabled, one must be of **average or above average intelligence**. However, learning disabilities are quite varied with no one characteristic being found in all cases. Most students with an LD, though, exhibit one or more of the following behaviors: be disorganized, have trouble listening and taking notes at the same time, have problems following directions, misinterpret things that are said, interrupt, ask/answer questions inappropriately, have unusual handwriting, use wrong verb tenses, leave beginnings or endings off of words, confuse similar letters, seem disorientated in time, and display excessive anxiety, anger or depression.

You may assist these students by tactfully referring them to our office; by asking them if they need any extra help or services; by writing what you say on the board; by providing them with your notes or an outline of your lectures; and at the beginning of each class, by reviewing what you taught in your previous lecture and summarizing what you'll go over that day.

Please refer anyone with a disability to our office (exts. 63606, C; 32180, M; 22019, B; 42011, T) and anyone with an LD or a suspected LD to Nancy Malta in Melbourne (ext. 33171) or Nancy Spotz in Cocoa (ext. 63664).

The OSD Newsletter
April, 1999 (2)

Some disabilities are obvious, while others, such as learning disabilities, are invisible. Public Law 94-142, the Individuals with Disabilities Education Act (IDEA), defines a learning disability as "a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, which disorder may manifest itself in an imperfect ability to listen, think, speak, read, write, spell, or do mathematical calculations. Such disorders include such conditions as perceptual handicaps, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia. Such term does **not include** children who have learning problems which are primarily the result of visual, hearing, or motor handicaps, of mental retardation, of emotional disturbance, or of environmental, cultural, or economic disadvantage."

Students with learning disabilities display many of the following learning problems:

1. **Poor study habits**
   - A. trouble with organizing and budgeting time
   - B. slow to start tasks and problems completing a task
   - C. trouble sustaining effort on a task
   - D. difficulty in identifying the main requirements of a task
   - E. problems utilizing reference materials
   - F. trouble integrating information from various sources
   - G. poor note taking ability
   - H. poor listening and test taking skills
2. **Discrepancy in quality of written and oral work**
3. **Attention span problems**
   - A. Overactivity, underactivity, or distractibility
4. **Language problems**
   - A. often substitutes easier words for more difficult ones
   - B. difficulty with verbalizing answers
   - C. refrains from participating in discussions or asking questions
   - D. forgets, confuses, or mispronounces words
   - E. has trouble defining easy words or describing objects
   - F. trouble with written language
5. **Perceptual problems**
   - A. trouble dealing with three-dimensional figures
   - B. problems locating specific information on a page
   - C. difficulty in distinguishing between similar sounding words
   - D. problems perceiving spatial attributes
6. **Poor short and/or long-term memory**
7. **Problems following directions**
8. **Possesses incoherent and disorganized thoughts**
9. **Lacks gestures when talking**
10. **Often confuses right and left sides**
11. **Motor coordination trouble**
    - A. problems with tasks requiring fine motor coordination
    - B. disorganized or sloppy gross motor coordination
    - C. fails to swing arms when walking or running
    - D. clumsy when walking or running
    - E. clumsy when holding pens or pencils
12. **Poor anxiety management skills**

Schmidt, R. (ed.). (1982). New Directions for Student Services. San Francisco: Jossey-Bass.

The OSD Newsletter
May, 1999 (3)

According to The Americans with Disabilities Act (ADA), someone is considered to have a disability if he/she has a physical or mental impairment that substantially limits one or more of his/her major life activities (such as eating, sleeping, walking, talking, hearing, seeing, learning, etc.); if he/she has a history of such an impairment; and/or if the person is considered to have the impairment. The OSD serves people with many types of disabilities such as: spinal cord injury, vision impairment/blindness, hearing impairment/deafness, head injury, learning disability, chemical dependency, mental illness, attention deficit/hyperactivity disorder, HIV/AIDS, and various illnesses (cancer, heart disease, diabetes, cerebral palsy, epilepsy, multiple sclerosis, and others).

The President's Committee on the Employment of People with Disabilities listed the following to be true in 1993:

1. It is estimated that approximately **50 million** Americans have a disability
2. Of these, 7 million have a developmental disability, mental illness or emotional disability
3. 1.5 million have a hearing impairment
4. 1.6 million have a visual impairment
5. 9 million are unable to walk ¼ mile without assistance
6. 1.5 million have partial to complete paralysis

There are several hundred students attending BCC who have disabilities. They may or may not have identified themselves and may or may not need accommodations. Utilizing some of the following **suggestions** could help students with disabilities, and might benefit those without disabilities, as well:

1. Make book lists, supplemental material lists, and your syllabus available several weeks prior to the beginning of the semester
2. Use multiple channels to present course content and assignments (written and oral)
3. Permit alternatives to written papers (e.g. oral presentations or taped work)
4. Use precise, clear language when lecturing and when explaining course requirements.
5. Speak only when facing the class
6. Provide written outlines of lectures, leaving space for student notes
7. Provide alternatives to your traditional examinations and/or utilize various types of tests (e.g. multiple choice, essay, fill in the blank, true-false, etc.)
8. When composing exam questions, try to avoid confusing questions, double negatives, unduly complex sentence structure, and questions embedded within questions.
9. Provide review sessions and study guides
10. Always encourage students and make time for their questions both in class and during your office hours
11. Begin all lectures with a review of what has been covered previously, and a preview of what will be covered that day
12. Try to make appropriate seating arrangements so that everyone can see and hear you
13. Permit the tape recording of your lectures
14. Avoid calling students who haven't volunteered to answer questions
15. Provide copies of overhead information and/or lecture notes
16. Try to reduce anxiety in your class by promoting a receptive atmosphere

The OSD Newsletter
August, 1999 (4)

Welcome back! The Office for Students with Disabilities hopes that you all had a wonderful summer. The first issue of the newsletter for this school term will discuss **Attention Deficit Hyperactivity Disorder**.

Definition

ADD or ADHD is a disorder which is manifested by an excessive amount of inattention, impulsiveness, and/or hyperactivity. There are four subtypes depending upon the characteristics involved. One is the *inattentive* type where the individual is easily distracted, forgetful, misses details, makes careless errors, appears to not listen, has trouble sustaining attention, is disorganized, and loses things. The second is the *hyperactive/impulsive* type where the person is always moving, feels restless, has difficulty remaining quiet, talks excessively, blurts out answers to questions, interrupts, and doesn't wait his/her turn. The third type is a combination of the first two. In the fourth type, the individual exhibits some of the characteristics, but an insufficient number to be diagnosed with ADHD. People with this disorder may or may not have learning disabilities.

Causes

A great deal of research is still being done, but several suspected causes of ADHD are toxins, diet, injuries, and heredity. In children with ADHD, it has been found that certain areas in the frontal lobe of the brain and the basal ganglia are approximately 10% smaller in size and activity than in other children. Genetic research has shown that dopamine (a neurotransmitter) pathways in the brain appear to play a major role in ADHD.

Diagnosis

Because there are no biological or psychological tests that specifically determine the presence of ADHD, diagnosing it is a complicated procedure that involves a medical examination, an assessment of intellectual, academic, social, and emotional functioning, and a gathering of information about the student's history from his/her family, teachers, and employers.

Treatment

Psychosocial interventions as well as several medications are used to treat ADHD. The use of medication is controversial, but if prescribed and used correctly, it is reported that 70-80% of people with ADHD respond favorably to it, and it often means the difference between a student being a success or failure in school.

Hints for Faculty

1. Include a statement on your syllabus that services are available from the OSD.
2. Permit the student to tape record lectures.
3. Assist the student with finding a notetaker or lab assistant, if requested.
4. Clearly define course requirements, dates of exams, and when assignments are due. If necessary, clearly define (in writing) the type of behavior you expect from students in your class.
5. Provide handouts and visual aids.
6. Use more than one way to explain information.
7. Break long assignments into short steps with time limits for each one
8. Provide study guides and review sheets for tests
9. Provide alternative ways for students to complete tasks (such as oral presentations)
10. When in doubt about how to assist a student, ask him/her and/or feel free to call the OSD (ext. 63606).

CHADD (Children and Adults with Attention Deficit/Hyperactivity Disorder

Please feel free to contact our office (ext. 63606), if you have any comments, questions, or suggestions. HAVE A GREAT SUMMER!!

The OSD Newsletter
October/November, 1999 (5)

Spinal Cord Injury

Imagine how you would feel if:
1. your talent and intellect were invisible and people only saw your wheelchair;
2. you had to ask for help getting over a threshold every time you needed to use the restroom;
3. you knew that a whole class had to be moved because you couldn't get to the second floor;
4. you needed someone else to open the building door for you every day…

The National Spinal Cord Injury Association defines Spinal Cord Injury (SCI) as, "damage to the spinal cord that results in a loss of function such as mobility or feeling." This is considered a different type of injury than back injuries such as ruptured disks or pinched nerves. SCI is categorized as complete and incomplete. There is no function below the level of the injury, and both sides of the body are affected equally, in the complete type. People who have incomplete injuries do have some feeling and/or voluntary movement below the level of the injury. Even though knowing the level of the injury helps to predict the body parts that will be affected, there are many causes of SCI, so each injury is unique. Causes may be motor vehicle accidents (42%), acts of violence (24%), falls (22%), sports (8% - 2/3 from diving), and diseases such as polio, spina bifida, and others. After age 45, falls are the leading cause.

There are many and varied effects of SCI such as the ability to move, feel, breathe, control body temperature, regulate blood pressure, control the bladder and/or bowel, sexual dysfunction, infertility, low blood pressure, and chronic pain. There are approximately 250,000-450,000 people in the United States who have some type of SCI. Of the 8,000 new injuries each year, about 82% are males between the ages of 16 and 30.

The OSD Newsletter
December, 1999 (6)

Visual Imparities

When asked, many people would state that if they had to lose one of their six senses, vision would be the one they would least want to lose. Humans are very visual creatures and in this day and age of technology, we use our vision more than ever. Since many people are afraid of the possibility of losing their own vision, some seem to shy away from understanding those that have visual imparities. For instance, many people do not know the difference between low vision, being legally blind, and being totally blind.

Low vision is a term used for persons who have any visual imparity that reduces their eyesight from 20/20 to just under 20/200 with corrective lenses. There are thousands of individuals that fall under this category, even some of you reading this letter. For most, having some vision loss is an inconvenience that can be corrected by wearing glasses or contact lenses, but for others, their vision cannot be corrected in this manner. Many with visual imparities see the world as if looking through a paper towel roll, and only have the middle vision. Others see only what these do not see, the outside of the tube and not the middle. Some see everything, but their world is dull and fuzzy, while others see the world clearly one day and not at all the next. When people with low vision enter college, there are many obstacles that stand in their way. They cannot see the board from the back of the room, they cannot read a test in regular print without getting a headache, or they have problems maneuvering around campus. Some of the accommodations that might be helpful for these students would be to make sure that they can sit in the front of the class so they can see the board, make handouts of overhead material and give to the student, and enlarge all written material for the student. These few accommodations can make all the difference in the world to a low vision student.

Legally blind is a term used for a person who has the vision of 20/200 after corrective lenses are used; this means that this person sees **at best** 20/200 with corrective lenses. These students have some vision and may still rely heavily on what little sight they still possess. As with the low vision students, these students face many obstacles

in their paths to college including all of the above items. In addition, these students might have problems finding transportaiton to and from school, finding visual aids to use in reading text and handout material, and adapting to changing their learning styles from visual to hearing. Some of the ways college employees can assist these students is to do all that they can do to see that adequate busing is available in their areas, allow students to bring visual aids to class, and understanding that the student may need individualized help in the classroom.

Blind is a term used for individuals who see very little or nothing at all. Solme blind students can see light and even some shapes, while others can see nothing at all. These students face altogether different obstacles than the low vision or the legally blind student. One of the obstacles that faces many of these students is teachers who do not stop to think about what they cannot see. For instance, when an instructor writes on the board and refers to items on the board as “this" and “that"(this is divided into that or this compound is combined with that), the blind student has no idea what the teacher is talking about. Another difficulty is that all of a blind student’s school material must either be read to the student or placed on tape. Another area that affects blind students is in testing. Blind students have a difficult time remembering all of the words to a long test question. To understand this, have someone read a multiple choice test question to you exactly as it is written on the test (you must have your eyes closed). After about the seventh or eighth word, you start to forget the beginning words. Our brains can only hold about seven things at one time. If a test question has 25 words in it, the student is in grave trouble. In addition, a blind student will use some sort of mobility assistance such as a cane, a seeing–eye-dog, or another person. It can be a very dangerous place for a blind student when furniture and equipment are moved from where that person is used to it being. Some things college personnel can do to help a blind student is to think about the necessity of moving something in the area where the student usually travels, give alternative testing such as oral testing whenever possible, and to pay attention to how lectures are worded.

This is only a short explanation of some of the difficulties that face students with visual imparities. If you would like to learn more, go to one of the Offices for

Students with Disabilities and speak with one of our staff, or better yet, go directly to a person who is visually impaired; he/she knows the most about what is needed. Students who are visually impaired already have more difficulties than other students at the college. These students are working hard and fighting just to be able to attend college. Therefore, please try to remember that these students need some help to succeed in college, and most of all, they need the encouragement, respect, and support of each and every one of us in the college.

The OSD Newsletter
January, 2000 (7)

Dwarfism

The Little People of America (LPA) organization defines dwarfism as having “an adult height of 4’10” or shorter” which is caused by some medical or genetic condition. There are over 100 types of dwarfism, and the ADA recognizes it as a disability. Approximately one in 10,000 births is affected by dwarfism and most cases result from parents of average stature.

Achondroplasia, occurring in one per 14,000 births, is presently the most common type of dwarfism. This is a genetic condition that results in disproportionately short arms and legs. A person with this condition has one dwarfism gene and one of average size at a certain location. If both parents have the condition, there is a 25% chance that their child will inherit the non-dwarfism gene from both parents, and will be of average size. There is a 50% chance that their child will inherit one dwarfism gene and one non-dwarfism gene, and there is a 25% chance that the child will inherit both dwarfism genes (double-dominant syndrome). The gene for achondroplasia was discovered in 1994, making genetic counseling available. This would be particularly useful in detecting the double-dominant syndrome, which is fatal.

Spondylo-epiphyseal dysplasia (SED) is the second most frequently occurring type, with one per 95,000 births. There is no cure for these conditions although some people undergo controversial limb-lengthening surgery. Another condition, proportionate dwarfism, results in short stature, but arms and legs that are in the same proportion as in an average sized person. This is often caused by a hormonal deficiency and can be treated medically.

People with dwarfism most often have normal intelligence and life spans. However, orthopedic complications are common. Other problems that might occur are:

(1) compression of the brain stem which causes an individual to stop breathing frequently while sleeping and also causes a failure to thrive

(2) hydrocephalus (excess fluid on the brain)

(3) obstructive apnea which is caused by the airway being too small

Today, people with dwarfism prefer to be called little people, people of short stature, or dwarfs. Recently, the term “midget” has come into disfavor. Most importantly, of course, is the fact that people with dwarfism should be treated with respect and dignity.

http://www.lpaonline.org/resources_req.htm
Heather Bell

The OSD Newsletter
(The Office for Students with Disabilities)
February, 2000 (8)

Multiple Sclerosis

What is MS?

Ms is a disease of the central nervous system. The myelin sheath coating around the nerves that acts as an insulator of the nerves, degenerates, which, in simplistic terms, causes the nerves and thus the body, to short-circuit. According to the International MS Support Foundation, "With multiple sclerosis, the loss of myelin appears to the naked eye as a hardened sclerotic (scar) area. These areas are multiple within the central nervous system, thus the term multiple sclerosis."

Causes of MS

To date, there is no known cause of MS. Research shows that there are several theories about the possible causes of this disease. Some theorists suggest that allergies play a major role in MS; others believe that a virus is involved, while others believe that where a person lives the first 15 years of his/her life has a substantial effect on the disease.

Characteristics of MS

- MS commonly begins between the ages of 15 and 50
- No two cases of MS are alike
- Remissions and exacerbations (improvement and relapse) occur
- Symptoms vary greatly from one individual to another and can range from mild difficulties with vision and gait to severe weakness and loss of control
- Multiple scattered areas in the nervous system are diseased
- Long periods of remission usually occur
- The person's body seems to turn against itself in an "autoimmune reaction"

Diagnosis of MS

There is not one specific test that can test for Multiple Sclerosis. The determination is usually made as a result of a neurological examination and the satisfaction of symptoms/characteristics. In two-thirds of MS cases, an elevated gamma globulin is present in spinal fluid, and in 80% of MS cases, special proteins called oligoclonal bands are found in the spinal fluid. In addition, electrical tests may be performed to indicate short-circuiting in the central nervous system, and magnetic resonance imaging (MRI) is very helpful in seeing the brain and the effects that MS has caused.

Frequent Signs and Symptoms of MS

- Visual - jerky eyes, double vision, loss of color vision, blurred or dimmed vision, blindness
- Speech - scanning speech, slurred speech
- Motor - weakness, paralysis, clumsiness, intention tremor, spasticity
- Bowel/bladder - frequency, urgency, incontinence, retention, constipation
- Fatigue

Management of MS

Good health habits are important for any illness and especially for MS. Since the body's immune system does not function correctly, maintaining a proper, balanced diet, promptly treating any infection, and getting plenty of rest is essential. There are many different drugs that are used to help with acute attacks, spasticity, fatigue, depression, etc. Physical therapy is something that many recommend for MS due to the spasticity and fatigue of the individual. Counseling is also recommended due to the depression associated with the disease.

Lynn Dallas, Disability Services Specialist, Office for Students with Disabilities

The OSD Newsletter
(The Office for Students with Disabilities)
March, 2000 (9)
Hearing Impairment

Hearing Impairment

Hearing impairments are very common; about one person in ten experiences some degree of hearing loss, and about one person in 100-experiences difficulty understanding speech. The ear consists of three parts: the external ear, the middle ear, and the inner ear. Hearing impairment occurs when there is obstruction, disease, or damage to one or more parts of the ear.

Communication Tips

1. Get the hearing impaired person's attention before speaking.
2. Look directly at the person when you speak.
3. Speak slowly and clearly. DO NOT exaggerate or over-emphasize words.
4. Don't be embarrassed to utilize pencil and paper to communicate.
5. Try to maintain eye contact. The eyes convey much to a hearing impaired person.
6. If an interpreter is present, talk directly to the hearing impaired person. REMEMBER, you are speaking with the hearing impaired person, not the interpreter.
7. If you are having problems getting your ideas across, try rephrasing or restating rather than repeating the idea.
8. Allow the hearing impaired person to sit where it is best suited for him/her.
9. Try to avoid standing in front of a light source such as a window. This makes it hard for a hearing impaired person to see your face clearly.
10. Provide a brief outline for films, lectures or movies. Even with an interpreter, it is difficult for a hearing impaired person to watch a film and the interpreter at the same time.
11. If you plan on having films or movies, select ones that have closed captioning.
12. Use as many visual aids as possible.
13. Try to avoid unnecessary pacing or speaking while facing the board. It is difficult to lip-read from a person who is moving, and impossible to do so from the side or back.
14. Try to slow down the pace of communication. This allows the student to assimilate the information and to respond.
15. Repeat questions or responses that are given from the back of the room.
16. Make sure that the hearing impaired person is not left out of getting vital information from things such as group discussions or syllabus changes.
17. Most importantly, if you have any questions about the hearing impaired, ask the person or come to the Office for Students with Disabilities on your campus.

Signs of a Hearing Loss

Signs you may need to have your hearing checked by a hearing professional:

1. Listening difficulty at restaurant with family and friends
2. Your hearing condition causes arguments with members of your family
3. You hear frequent jokes about your hearing ability
4. Your spouse often tells you he/she frequently has to repeat things to you
5. You attend church services or other social events less often because of your hearing problem
6. You find it necessary to turn up the volume on your TV or radio beyond normal level
7. You experience feelings of frustration when you converse with others and have difficulty hearing everything they say

If you answered yes to some of these questions, you might be suffering from a hearing loss. Make an appointment to see your physician and get a complete hearing exam and test.

(Coastal Hearing Aid Center 1997)

The OSD Newsletter
(The Office for Students with Disabilities)
April, 2000 (10)

EPILEPSY & SEIZURES

What is Epilepsy?

Epilepsy is a common neurological disorder caused by disturbances in the normal electrical functioning of the brain. The normal patterning of the brain is disrupted by sudden and intense electrical bursts of energy which can affect a person's consciousness, bodily movements, or sensations. These physical changes are called epileptic seizures. This and more information can be found at the National Institute of Neurological Disorders and Stroke's website at www.drkoop.com.

What to do when a person is having a seizure

1. DO NOT PANIC. "An uncomplicated convulsive seizure in someone who has epilepsy is not a medical emergency, even though it looks like one." (Epilepsy Foundation www.efa.org)
2. Try to stop the person from falling and causing bodily harm.
3. Cushion the person's head.
4. Loosen any restrictive neckwear.
5. Turn person on his/her side.
6. Put NOTHING in the person's mouth.
7. Look for an ID bracelet such as a Medicalert bracelet or necklace.
8. DO NOT hold the person down.
9. As the seizure ends, offer help to the person. Seizures usually last under five minutes and do not require medical assistance or an ambulance.

When should an ambulance be called?

1. If the seizure lasts more than 5 minutes
2. If there is no epilepsy/seizure disorder ID
3. If the person has a slow recovery from original seizure (lack of consciousness), a second seizure, or difficulty breathing after the seizure
4. If the person is pregnant or has other medical ID or conditions
5. If there are any signs of injury.

(Epilepsy Foundation)

Conclusion

Remember, if a person in one of your classes or in your office has a seizure, **be calm**. A seizure can be a frightening experience due to the intense muscle contractions of the person having it, but know that it is usually not as harmful as it appears. If you are not sure what to do when a person is having a seizure, call someone for assistance and follow the directions above. With epilepsy, as with any disorder, if you would like more information, just ask one of our staff members, go to one of the sites mentioned above, or ask a person who has epilepsy.

Lynn Dallas, Disability Services Specialist, Palm Bay

The OSD Newsletter
May, 2000 (11)

Communicating with People who have Disabilities

There is more to a person than merely his/her disability. Try to remember that when communicating with people who have disabilities; make sure to put the person first rather than the disability. For example, say, “person with mental retardation,” rather than “mentally retarded person”. Additionally, you may follow the “10 Commandments of Etiquette for Communicating with People with Disabilities” as outlined by the President’s Committee on Employment of People With Disabilities.

1. When talking with a person with a disability, speak directly to that person rather than to his/her companion or sign language interpreter.
2. When introduced to a person with a disability, it is appropriate to offer to shake hands. People with limited hand use or who wear an artificial limb can usually still shake hands. Shaking hands with the left hand is an acceptable greeting.
3. When meeting a person who is visually impaired, always identify yourself and others who are with you. When conversing in a group, remember to identify the person to whom you are speaking.
4. If you offer assistance, wait until the offer is accepted. Then listen to or ask for instructions.
5. Treat adults as adults. Address people who have disabilities by their first names only when extending the same familiarity to all others.
6. Leaning on a person’s wheelchair is similar to leaning directly onto a person, and is often annoying. The chair is part of the personal body space of the person who uses it.
7. Listen attentively when you are talking with a person who has difficulty speaking. Be patient and wait for the person to finish, rather than correcting or speaking for the person. If necessary, ask short questions that require short answers, a nod, or a shake of the head. Never pretend to understand if you are having difficulty doing so. Instead, repear what you have understood and allow the person to respond. The response will clue you in and guide your understanding.
8. When speaking with a person who uses a wheelchair or crutches, place yourself at eye level in front of the person to facilitate the conversation.
9. To get the attention of a person who is deaf, tap him/her on the shoulder or wave your hand. Look directly at the person and speak clearly, slowly, and expressively to determine if he/she can read your lips. Not all people who are deaf can read lips. For those who can, be sensitive to their needs by placing yourself so that you face the light source and keep hands, cigarettes, and food away from your mouth when speaking.
10. Relax, and do not be embarrassed if you happen to use accepted, common expressions such as, “See you later,” or “Did you hear about that?” that seem to relate to a person’s disability. Do not be afraid to ask questions when you are unsure of what to do.

The OSD Newsletter
August, 2000 (12)
Cerebral Palsy (CP)

Cerebral palsy, a group of disorders characterized by loss of movement or other nerve functions, is a lifelong disorder that affects approximately 500,000-700,000 Americans. It is caused by damage to the brain that occurs during fetal development or shortly following birth. This damage may be precipitated by illness during pregnancy, complications with premature delivery, an inadequate oxygen supply to the baby, or as the result of lead poisoning or a viral infection. Acquired CP may be caused by a head injury resulting from such things as motor vehicle accidents, falls, or child abuse. It is incurable, non-progressive, uncommunicable, does not affect life expectancy, and in most cases, it cannot be prevented.

There are three principal types of CP: spastic, dyskinetic (athetoid), and ataxic. Approximately 50% of the cases are of the spastic type and involve stiff and difficult movement. Dyskinetic CP involves development of abnormal movement such as twisting and jerking, and it affects about 20% of the cases. Ataxic CP affects approximately 10% of the cases and sufferers may experience tremors, unsteady gait, loss of coordination, and abnormal movements. The balance of the cases is comprised of mixed types. Symptoms may include seizures, muscle contractions, difficulty sucking or feeding, irregular breathing, delayed development of motor skills, mental retardation, speech abnormalities, visual abnormalities, hearing abnormalities, spasticity, joint contractures, limited range of motion, and/or peg teeth.

Although there is no cure for cerebral palsy, various medications are used to reduce tremors and spasticity, and anticonvulsants are utilized to prevent or reduce the frequency of seizures. According to the symptoms, people with CP may also benefit from physical therapy, braces, hearing aids, glasses and other adaptive equipment or devices.

The OSD Newsletter
(The Office for Students with Disabilities)
September, 2000 (13)

WHAT IS HIV/AIDS?

Human immunodeficiency virus (HIV) is a virus that attacks the immune system of the human body and weakens its natural ability to fight off infections. By itself, HIV is not deadly; it attacks the body's immune system, allowing infections to take hold. It attaches itself to the white blood cells (also known as helper T cells), which depletes the T cells and lessens the body's natural defense against infections.

Acquired immune deficiency syndrome (AIDS) is incurable. It can take less than 5 years or as long as 15 years for HIV to turn into full-blown AIDS.

WHO GETS HIV/AIDS AND HOW IS IT SPREAD?

Since 1981, more than 688,000 Americans have been diagnosed with AIDS, and more than 400,000 have died. More than 40,000 people in the US are diagnosed with HIV every year. The group with the highest percentage of cases is the age group of 24 to 44 (the most sexually active age group), and new cases among people of color and woman are increasing. However, there is an unprecedented number of researchers working to find a cure for HIV and AIDS. Due to a new class of drug, protease inhibitors, many with HIV and AIDS are living longer, more productive lives. These drugs have helped to reduce the number of AIDS related deaths by almost ½ from 1996 to 1997, and as a result, AIDS have dropped from the 8th leading cause of death in the U.S. to the 14th.

HIV is found in bodily fluids such as blood, semen, vaginal fluids, and breast milk, and can only be passed from person to person in very specific ways. These ways include sexual intercourse, through infected blood (though this is rare today due to blood screening), and from infected mothers to their babies while still in the womb or through breast feeding. HIV cannot be spread by casual contact such as coughing or sneezing, or hugging and touching. It cannot be spread by air, water, or in food, or by sharing cups, bowls, and it cannot be transferred from toilet seats. Lastly, HIV cannot be transmitted by biting insects such as flies and mosquitoes, because the amount of blood transfer in too minute. (BBC World Service www.bbc.cl.uk/worldservice)

SYMPTOMS

Once HIV enters the body, it can take about a month or two before creating flu-like symptoms (not everyone has symptoms) such as fever, chills, night sweats, skin rashes, headache, malaise, swollen lymph glands, and general discomfort. There can be a reemergence of these flu-like symptoms several months later, and generally there is a five to seven year period after this that has no HIV symptoms (this delay can range from a few months to more than 10 years). Later symptoms, occurring months or years before onset of AIDS, may include fatigue, mild weight loss, frequent fevers and sweats, swollen lymph glands, persistent yeast infections, persistent skin rashes, pelvic inflammatory disease, short term memory loss, frequent and severe herpes infections, and shingles.

As chronic HIV progresses, the immune system grows weaker and weaker allowing "opportunistic" infections to occur. These infections include pneumonia, HIV infection of the brain, toxoplasmosis of the brain, fungal infections, HIV wasting syndrome, yeast infections, Kaposi's sarcoma (a form of skin cancer), tuberculosis and related infections, cryptosoridiosis infection of the intestine, herpes, lymphoma, and cytomegalovirus infections of the retina and other organs. HIV and AIDS can involve virtually every organ in the body. Therefore, many conditions can be mistaken for AIDS such as cancer, senile dementia, gastrointestinal infection, colitis, inflammatory bowel disease, and depression. (www.planetrx.com)

WHAT CAN WE DO TO HELP?

With HIV and AIDS, as with any disease, the best thing that anyone can do is to see the person not the disease. Fair, compassionate interaction can make a world of difference to a person who is sick and scared, especially if others are afraid to be around that person and afraid to interact with him/her. Please remember

that we all, as human beings, need acceptance, compassion, and love, no matter what our disability is, be it a disability of HIV and AIDS or the disability of attitude.

The OSD Newsletter
(The Office for Students with Disabilities)
October, 2000 (14)

What is Hepatitis?

Viral hepatitis is one of the most common infectious diseases in the world. There are at least five distinct hepatitis viruses, A, B, C, D, and E, and all of them affect the liver in one way or another. There are also several non-viral forms including autoimmune hepatitis and toxic hepatitis. Toxic hepatitis is caused by toxins and drugs that directly injure the liver. Some examples are long term alcoholism, high doses of acetaminophen (active ingredient in Tylenol), or accidentally eating poisonous mushrooms.

Types of Hepatitis

A- is the most common strain, with up to 2,000,000 people infected each year in the U.S. Most individuals infected by this strain of hepatitis recover completely within a month and have no lasting liver damage. Once one has type A, one can never get it again because the body develops immunity. A and E are mainly spread by contaminated food or water.

B- is the next most common strain with 150,000 to 300,000 people infected each year in the United States. Hepatitis B can be either chronic or acute, and enters the body through infected bodily fluids, very much like AIDS is transmitted. Hepatitis D is dependent on Hepatitis B, and one can only get the D strain if he/she already has B. Hepatitis D is also transmitted by bodily fluids.

C- infects 28,000 to 180,000 people each year, and can either be acute or chronic. This form of hepatitis used to be transmitted through blood transfusions, but since 1992, blood supplies are routinely screened for the virus, so now it is transmitted mainly by sexual contact and sharing of infected needles. Hepatitis C is the most likely of all of the viruses to cause chronic illness; it progresses slowly, usually over a course of 10 to 30 years.

D- infects about 5,000 people in the United States each year.

E- infects an unknown amount of individuals each year, but the amount is thought to be rather few.

Acute hepatitis tends to run its course and symptoms usually disappear within four to sixteen weeks without any specific treatment. **Chronic hepatitis** will be either persistent (CPH) or active (CAH) with CPH being more common. CPH has few or no symptoms, and results in few long-term problems. CAH on the other hand, has many symptoms and can lead to cirrhosis, liver failure, or liver cancer if left untreated.

Symptoms

Many people with hepatitis will feel only mildly ill, if sick at all. Some of the symptoms include fever, malaise, nausea and vomiting, anorexia, abdominal pain, diarrhea, fatigue, headache, dark urine, jaundice skin and/or eyes, itchy red hives, foul breath with bitter taste, bleeding, and altered mental state. Some conditions that may be mistaken for hepatitis are mononucleosis, hepatic malignancy, Wilson's disease, gallbladder disease, appendicitis, and peptic ulcer disease.

Treatment

Acute hepatitis needs no specific treatment, but it is recommended that one avoid alcohol, eat a healthy diet, and get plenty of rest while recovering. Chronic hepatitis can be managed with medications and complications can be treated as they arise. One of the main drugs used to treat chronic hepatitis B and C is interferon, which helps to delay the progression of the disease to cirrhosis. Liver transplants are only considered in end stages of liver disease and occasionally result from chronic hepatitis B and C. Treatment periods for the different types of hepatitis vary, and the duration for acute hepatitis varies as follows: A- lasts less than 2 months, B- averages 60 to 90 days, C- is usually chronic that can continue for years, D- duration is unknown, and E- averages 26 to 42 days.

Although hepatitis cannot always be prevented, there are a few things that one can do to slow down the progression of the disease. These include;

- Avoid alcohol (it is a leading cause of liver damage)

- Take as few drugs as possible (they are metabolized through the liver)
- Maintain good hygiene (this reduces the incidence of hepatitis)
- Take antioxidant supplements (research suggests vitamin E and selenium help strengthen the liver)
- Take milk thistle (research in Germany shows that milk thistle helps liver function)

Conclusion

As with any individual who has a chronic disease, individuals with hepatitis may have days where they feel fine and days where they are sick and in pain. We, as educators, need to understand that individuals with this disease can feel fine one day and end up in the hospital that evening. As with all disabilities, we need to listen and learn from the person with the disorder. No one can explain what it is like to have hepatitis like someone who is living the life. All we can do is to understand the disability and work with the students to help them be successful in their college career.

The OSD Newsletter
(The Office for Students with Disabilities)
November, 2000 (15)

DIABETES

What is Diabetes?

Diabetes, or diabetes mellitus, is a disorder where the body's blood sugar (glucose) remains too high and causes problems. This disease involves the hormone insulin, which normally allows one's cells to use glucose as fuel. Diabetes occurs when the body either does not produce enough insulin or when the body resists the hormone's action, or both. Without insulin, the body does not have proper access to its basic source of energy/food. There are two major types of diabetes: Type 1 and Type 2. In Type 1 diabetes, known as juvenile-onset, Brittle, or insulin-dependent diabetes, there is a profound shortage, or lack, of insulin produced by the pancreas. In Type 2 diabetes the pancreas produces less insulin than is needed, and the body resists correct functioning of the insulin. Other forms of diabetes include gestational diabetes (impairment of glucose tolerance during pregnancy), secondary diabetes mellitus (caused by medication or illness), and malnutrition-related diabetes (observed primarily in developing countries).

How Common is Diabetes?

Current estimates suggest that 12 – 15 million Americans have diabetes, although only about half of these are diagnosed. Approximately 700,000 new cases appear annually, and as many as 150,000 deaths are attributed to this disease each year (as many as 300,000 – 400,000 more may have diabetes as a leading contributing factor to death). For Type 1 diabetes, onset occurs between ages eight and 12, and the sex ratio appears to be equal. With Type 2 diabetes the age of onset is usually (but not always) after age 40 with a higher rate of females with the disorder than males.

Theoretical Causes

Type 1 diabetes is thought to be inherited and caused by an "alteration in the immune system that places the beta cells at risk for damage. Beta cells are the insulin-producing cells of the pancreas." (www.planetrx.com) Researchers believe that such factors as viruses (like mumps, hepatitis, and coxsackievirus), diet, and environmental toxins can trigger the genetic tendency to develop the immune system alteration. In Type 2 diabetes, it is thought that a genetic predisposition may exist.

Symptoms

Type 1

- Weight loss despite high appetite
- Failure to grow
- Abdominal pain
- Low blood pressure and rapid pulse (signs of dehydration)

Type 2

- Skin infections
- Tingling in the feet
- Itching

Common for Both Types 1 & 2

- High blood glucose
- Excessive urination (polyuris)
- Excessive thirst and hunger (polydiposia and polyphagia)
- Fatigue and lethargy
- Blurry vision
- Frequent infections

Possible Complications

- Neuropathy (abnormality of the nervous system)

- Retinopathy (disorder of the retina)
- Nephropathy (abnormality of the kidneys)
- Cardiovascular disease, including heart attack and stroke
- Foot problems
- Excessive weight gain
- Hypoglycemia (low blood sugar)
- Coronary artery disease
- Cerebral artery disease
- Microvascular disease related to the eye, kidney, and nerves
- Cataracts
- Glaucoma
- Circulation problems
- Charcot's joint
- Diseases related to the eye, kidneys, and nerves including blindness

Treatment

The goal of treatment is to manage the body's glucose by diet, exercise, and medication (either oral drugs or injected insulin). Diabetes is an extensive chronic disease that can have complications ranging from gangrene to blindness, so it should not be taken lightly. If you suspect that you may have diabetes make an appointment with your physician as soon as possible. If the doctor prescribes medication, take it as prescribed. Eat a healthy diet that is high in protein and fiber, and low in sugar and fat. In addition, stay away from alcohol because it interferes with normal glucose utilization, and it can set up the body for hypoglycemic ups and downs. Exercise regularly with aerobic exercise to help maintain a more stable blood sugar level. In addition, research shows that several supplements and herbs can be beneficial to blood sugar maintenance. These include Vitamin E (helps lower blood sugar levels), Chromium (helps in insulin syntheses and blood sugar control), Psyllium seed (good source of soluble fiber), and Fenugreek seeds (also high in fiber).

Conclusion

With a disease as potentially debilitating as diabetes, we as educators need to understand the disease and have empathy as to what the student is enduring. Allow the student to sit in front of the class and enlarge tests if his/her vision is affected. Permit the student to leave the room for use of the restroom if his/her kidneys are affected. Be understanding regarding excessive absences if the student needs to see his/her doctor, or if he/she feels too ill to get out of bed. Be supportive when the student comes to you to explain the difficulties he/she is having. There may be side-effects of the disease that you may not know about. The best thing you can do for students is to listen to them and to understand their situation.

The OSD Newsletter
(The Office for Students with Disabilities)
Jan., 2001

CANCER (A BRIEF OVERVIEW)

What is Cancer?

According to OnHealth.com's Cardiovascular Center, "the fundamental cause of all cancer is a change, or mutation, in the nucleus of a cell." For a healthy cell to mutate, its genetic code must be reprogrammed for constant, uncontrolled cell division. Scientists believe that about 10 million of the 300 trillion cells in the human body die and are replaced each second. With this amount of change, it is easy to see how mutation can occur, but special cells from a human's immune system somehow recognize these mutant cells and destroy them before they can multiply. Nevertheless, some of these mutant cells survive and multiply, thus causing cancer.

What Causes Cancer?

The causes of cancer are very complicated and involved, so experts speak in terms of "risk factors." "Any habit, trait, or use of a substance that increases the odds of getting cancer is a risk factor, and the risk for nearly all cancers increases with age." There are also inherited or familial predispositions that are also risk factors. Environmental risk factors relate to where and how one lives. Most common cancers are linked to one of three environmental risk factors: smoking, sunlight, and diet. In addition, many substances in the environment have been identified as carcinogenic, in most cases, high levels of these substances are needed to cause cancer. All of these factors can contribute to cancer, but there needs to be a "multifactory hit" of age, inherited predisposition, general health, and carcinogenic exposure to cause cancers.

Cancer Trends

Medical technology and public education have helped to reduce the rate of cancer fatalities. Several cancer research organizations also attribute the decline in cancer deaths to a decline in smoking and to more people undergoing early detection screening tests. Data shows that there has been an average decline in cancer of 0.8 percent per year from 1990 to 1997. The rate of breast cancer remained the same during the 1990's, but the rate of deaths from breast cancer has dropped about 2 percent each year between 1990 and 1995 and has decline even more since then. The death rate of lung cancer is declining for men, but it is increasing for women. Also, researchers are seeing a decrease in deaths due to cervical cancer due to early detection by pap smears. Now more than ever, a person's chance of surviving cancer is quite high if the cancer is detected in its early stages. Even with this knowledge, 1.2 million Americans will be diagnosed with cancer this year, and the disease will take 560,000 of these lives.

Prevention (Brief Overview)

- ✓ Do not smoke or use chewing tobacco
- ✓ Stay out of the sun
- ✓ Eat a healthy diet
- ✓ Drink alcohol only in moderation
- ✓ Exercise regularly
- ✓ Get regular screening for cancer
- ✓ If work exposes you to know carcinogens, follow safety guidelines
- ✓ Avoid exposing self to carcinogenic chemicals at home, and when using such chemical use as instructed

Conclusion

As one can see, cancer is a major health issue in the United States. There is just too much information to put into one little newsletter, so we are going to be running a series of newsletters dedicated to the education of specific types of cancers such as breast, ovarian, lung, skin, and colon.
Cancer, as with any disease, takes its toll both physically and mentally on the person who is diagnosed with it as well as his/her family. Patience and understanding of the persons physical and psychological health can go a long way in helping the person succeed in the educational arena.

The OSD Newsletter
(The Office for Students with Disabilities)
Feb., 2001

Lung Cancer

Description

Lung cancer is the leading cause of cancer death in the United States. It is also the most common form of noncutaneous (non-skin) cancer. It is responsible for 32% of cancer deaths in men, and 25% in women, with about 180,000 new cases each year. The predominant age group of this disease is 45 to 70 years. Lung cancer is broadly defined into two types: small cell or non-small cell cancers. Small cell cancer comprises about 25% of all lung cancer cases. In this type of cancer, the cells are small, but they can multiply fast and create large tumors, as well as spread to the lymph nodes and other organs in the body. Small cell cancer is the most aggressive type of lung cancer. Although small cell cancer responds to chemotherapy and radiation, it also almost always reoccurs. Non-small cell cancer is more common, consisting of about 75% of lung cancer. There are four main types of non-small cell cancer: Adenocarcinoma (most common), Squamous cell carcinoma (second most common), Large cell carcinoma (about 10%), and Bronchioalveolar cell carcinoma (about 5%) (www.planetrx.com).

Characteristics of Lung Cancer

- Leading cause of cancer death in the U.S. for both sexes
- Often no symptoms in early stages
- Later stage symptoms include coughing, wheezing, and weight loss
- Primary cause is tobacco smoking
- Also may be caused by other lung carcinogens
- Often metastasizes (spreads) to other parts of the body
- Prognosis is poor even with early detection
- Usually treated with surgery, radiotherapy, and chemotherapy
- Can be prevented effectively by avoiding exposure to lung carcinogens

Symptoms

- A cough that lasts and worsens with time
- Persistent chest pain
- Blood-streaked sputum (phlegm), or coughing up blood
- Wheezing, shortness of breath
- Hoarseness
- Frequent bouts of pneumonia or bronchitis
- Swelling of the face and neck
- Loss of appetite
- Weight loss
- Weakness and fatigue
- Unexplained fever

Causes and Risk Factors

The established cause of primary lung cancer (cancer that originates in the lung) is exposure to lung carcinogens. These carcinogens include:

- Tobacco/marijuana smoking
- Secondhand smoke
- Heavy metals
- Asbestos
- Industrial carcinogens (chloromethyl ether)
- Air pollutants
- Radon

All of the above causes fall under the heading of risk factor with the addition of family history of lung cancer, lung scarring, and chronic obstructive pulmonary disease

Self-Care and Prevention

Although the only accepted treatments of cancer are surgery, chemotherapy, and radiation therapy, there are several alternative approaches that can be helpful, especially for relieving the symptoms of cancer and for prevention of cancer. These alternative approaches include meditation, self-hypnosis, visualization, and nutrition therapy. Lung cancer may be prevented if only people would do the following:

- Not smoke
- Avoid cancer-causing substances
- Get antioxidants (nutrition therapy)
- Have early detection

The OSD Newsletter
(The Office for Students with Disabilities)
March, 2001

Breast Cancer

Description

Because the breast is not a vital organ, the disease of the breast itself is not the main concern of the medical community. It is when the cancer spreads to other areas including vital organs that the problems begin. Breast malignancies begin in the milk glands, milk ducts, fatty tissue, or connective tissue of the breast. There are several types of breast tumors. Ductal carcinoma in situ (cancer of the milk ducts) and lobular carcinoma in situ (cancer of the milk glands) have a better prognosis than other tumors because they are confined to the ducts or glands. In infiltrating (or invasive) ductal carcinoma or infiltrating lobular carcinoma, the cancer has spread beyond the ducts or glands to surrounding tissue and organs. Infiltrating ductal carcinoma accounts for about 80% of all breast cancers, whereas infiltrating lobular carcinoma accounts for only about 10% - 15% of invasive breast cancers. Other breast cancers include medullary carcinoma, tubular carcinoma, inflammatory carcinoma, and Paget's disease of the nipple. One in eight American women will develop breast cancer sometime in their lives. The rate of breast cancer is higher than it has ever been, but many believe that this is due not to an increase in the prevalence of the disease, but to better detection techniques and an increase in public awareness. Approximately 150,000 new cases of breast cancer are diagnosed annually, but the mortality rate has dropped thanks to earlier detection and improved treatments. Even considering this, breast cancer is the second leading cause of cancer death in women in the United States, behind lung cancer.

Symptoms

- A breast lump or thickening that may or may not be painful
- Change in breast size, shape or symmetry - for instance, one breast becomes higher
- Flattening or indentation on skin of breast
- Dimpling, rippling, or scaling of skin on breast
- Change in breast skin temperature, most often a warm or hot patch
- Dark, bloody, or clear nipple discharge
- Nipple itching, scaling, burning, dimpling, or turning inward
- Lasting pain or tenderness in breast
- Swelling in the underarm
-

Causes and Risk Factors

There has not been any definite cause for breast cancer established, but some believe that it may be related to a genetic predisposition. Some also believe that dietary fat, alcohol consumption, and environmental factors may play a role in breast cancer. There are a number of risk factors that are present for breast cancer. They include:

- Being female (although men may get it, also)
- Prior history of breast cancer
- Prior history of breast biopsies revealing atypical changes
- Prior history of endometrial or ovarian cancer
- Breast cancer in first-degree relatives such as mother, sister, or daughter
- Early menarche (having first period at a young age)
- Late menopause
- Nulliparity (not having any children)
- First full-term pregnancy after age 30
- Carrier of BRCA1 or BRCA2 genetic mutations
- Being older than 50 years of age

Possible risk factors (but studies remain inconclusive):

- High dietary fat intake (35% or more of daily calories)
- Moderate to heavy alcohol consumption

- Sedentary lifestyle
- Obesity (40% over ideal body weight)
- Radiation exposure
- Exposure to pesticides and other environmental pollutants
- Estrogen replacement therapy in postmenopausal women

Self-Care and Prevention

Beyond the traditional treatment of breast cancer which includes surgery, radiation therapy, chemotherapy, hormone therapy, and experimental treatments such as bone marrow transplantation, there are other things one can do to treat breast cancer. One of these alternative treatments is vitamin therapy that includes vitamins such as vitamin C and vitamin E. It is also recommended that one should eat dark green vegetables, yellow and orange fruits, citrus fruit and bell peppers, wheat germ, seafood, legumes (especially soybeans), and poultry. In addition, green tea is recommended due to its ability to inhibit an enzyme that allows cancerous tumors to grow and spread and its other anticancer effects. Also, milk thistle is recommended because it is such a potent liver cleanser and strengthener. Research has also shown that Omega 3 fatty acids may offer benefits, as well. For the mental well being of the cancer patient, yoga, meditation, and group support is recommended. Even though there is no known way to prevent breast cancer, there are several ways to reduce the risk factors including:

- Eating a nutritious diet that is low in animal fat and high in fiber
- Limiting alcohol use
- Early detection
- Doing monthly breast self exams
- Having routine mammograms

The OSD Newsletter
(The Office for Students with Disabilities)
April, 2001

Skin Cancer

Description

With more than 800,000 new cases each year, skin cancer is the most common type of cancer in the United States. Luckily, skin cancer is easy to diagnose and if treated in its early stages, it is highly curable. There are three common types of skin cancer: basal cell carcinoma (BSS), squamous cell carcinoma (SCC), and melanoma. The skin is the largest organ in the human body, and it serves as a barrier to protect vital organs, bones and tissues from injury, temperature extremes, and infectious agents. There are different layers in the skin, and these layers coincide to the different types of skin cancer. Squamous cell carcinoma (SCC) occurs in the skin's flat squamous cells, the uppermost layer of the epidermis. Basal cell carcinoma (BCC) arises in the round basal cells, located beneath the squamous cells. Melanoma mutates in the melanocytes, the cells that produce the skin pigmentation called melatin (this is why skin cancer is common among Caucasians but rare in African-Americans). Melanoma is the most serious form of skin cancer, but it is also the most rare, comprising only about 5% of all cases.

Characteristics

- Most common type of cancer in the United States
- Incidence is steadily increasing
- Divided into three types: melanoma, basal cell carcinoma, and squamous cell carcinoma
- Melanoma is the most serious type, and has causes other than sun exposure
- All forms are highly curable if treated early
- Preventable by avoiding sun exposure

Symptoms

- New skin growth (not all skin cancers look alike: a growth may be a smooth, pale, shiny or waxy lump; a hard, red lump; a flat, rough, scaly, red spot; or a flat, scar-like lesion of the chest or back)
- Any sores or spots that don't heal, especially those that itch, hurt, bleed, scab, or crust
- Sores or spots that change size, color, shape, or texture
- Sores or spots that arise on skin areas that have been exposed to previous radiation treatments

Melanoma can arise from moles or from normal skin. Check the skin of the body for the "ABCDE" warning signs of melanoma:

- Asymmetry: one side of a mole or skin spot does not match the other side
- Border: irregular, notched, jagged edges
- Color: different colors within a mole, such as tan, brown, blue, black, red, or white
- Diameter: and change in size or any mole greater than six millimeters (about the size of a pencil eraser)
- Elevation: any growth that rises above the skin surface

Other signs include:

- Change in skin texture such as scaling, crusting, or oozing
- Change in consistency such as hardening or softening of the skin
- A mole feeling hard, lumpy, swollen, or itchy
- A mole beginning to bleed or ooze.
- Be aware of scaly, red or brown patches on the skin; this may be actinic keratoisis or precancer

Causes and Risk Factors

It is widely believed that ultraviolet (UV) radiation exposure causes skin cancer. Some theorize that when UV radiation passes through the skin it damages the DNA within the skin cells. Researchers believe that sometimes, the body's attempt to repair the DNA goes awry, leading to excessive cell growth and tumor

formation. There is also a belief that skin cancer might be linked to environmental pollutants such as coal, tar, pitch, creosote, arsenic, and radium.

Risk factors include:

- Age: older adults are particularly at risk
- Fair skin: especially skin that burns or freckles easily
- Personal or family history of melanoma
- Residence in sunny regions (e.g. Hawaii, California, **Florida**, Sun Belt states)
- Chronic or repeated sun exposure in childhood and/or adolescence
- Episodes of blistering sunburn in childhood
- Blue eyes and red or blonde hair
- Moles present at birth
- Presence of any Dysplastic Nevi
- Occupational exposure to arsenic, radium, coal, tar, pitch, or creosote

Self-Care and Prevention

- Avoid going out from 10:00 am to 3:00 pm when the sun's rays are strongest
- Wear broad-brimmed hats and protective clothing when going outside
- Use sunscreen daily. Experts recommend using one with a sun protection factor (SPF) of 15 or higher; re-apply it often
- Don't use sunlamps or go to tanning salons - these are also sources of UV radiation
- Keep in mind that snow, sand, and water all reflect the sun's rays
- Some sources say that certain vitamins can help prevent skin damage following sun exposure
- Certain chemicals, called psoraiens, may increase sun-sensitivity in some individuals. Psoraiens are found in carrots, celery, parsley, parsnips, and limes. Not everyone is affected by these chemicals, but those who are may want to avoid eating or even handling psoraien-containing foods before going out into the sun
- Yoga and mediation can be used in general well being to reduce stress and they can also help in dealing with pain
- Guided imagery and visualization can help mobilize the body's immune defenses to help the body to better fight off cancerous growths
- Nutrition therapy can help to prevent skin cancer such as vitamins C and E along with selenium, vitamin A, vitamin E, and omega-3 oil or gamma linoleic acid

In addition, it is a good idea to do a routine self examination which includes:

- Looking for any changes in moles, warts, birthmarks, scars, and spots. Look for any new markings.
- Examining your scalp by lifting up your hair and parting it in various places. Men with facial hair should also look at the skin under the hair.
- Examining all skin surfaces. Don't forget the backs and fronts of your hand, the bottom of your feet, your fingernails, buttocks, and genitalia. Also, take extra care in examining your face, neck, and ears, which are common sites of skin cancer.
- Running your fingers over your entire body, noting any bumps or rough, scaly patches. Don't forget your scalp, and be especially careful with the skin on your back and shoulders
- Closely feeling each mole, noting any tenderness, itching, pain, or bleeding.

The OSD Newsletter
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May, 2001

Colon Cancer

Description

"The colon is a 5-foot-long lower segment of the intestinal tract where water is reabsorbed and waste material is stored. It's divided into several segments, and cancer of the colon can affect any one of them." (www.planetrx.com) Colon cancer usually starts with the formation of polyps, or precancerous growths, and cancer occurs when the cells become abnormal and divide out of control, causing a tumor. Colon cancer is the second most common noncutaneous (non-skin) cancer in the U.S., with about 155,000 new cases diagnosed each year. Even though death rates have fallen in recent years, approximately 55,000 people still die from colon cancer, yearly. Many believe that the decrease in mortality is due to the increased knowledge about the disease's causes, treatments, and prevention. Genetic factors account for about one in every seven cases of colon cancer. A major contributing role is played by nutrition. Colon cancer is most prevalent in Western countries and countries that have adopted Western-style, high-fat diets. A diet rich in vegetables and high-fiber foods such as whole grain breads and cereals may help to reduce the risk of colon cancer. The risk of developing colon cancer begins to increase at age 40, and most cases occur in people between the ages of 60 and 70, with neither sex having a higher rate than the other.

Characteristics

- Cancer of the large intestine
- Family history and personal medical history determine risk
- Diet also influences risk
- Early detection is critical for treatment

Symptoms

- Blood in the stool
- Black stools (which may point to bleeding)
- Changes in the size or shape of the stool (for instance, narrow stools) that last more than one week
- Constipation and diarrhea in alternating cycles
- A feeling of incomplete emptying of the bowel
- Pain, cramping, discomfort, or swelling in the abdomen
- Nausea and vomiting
- Weight loss
- Fatigue and weakness (from anemia caused by bleeding in the intestine)

Causes and Risk Factors

Again, no known cause of colon cancer has been identified, but there are several risk factors related to colon cancer. These include:

- Family history of colon cancer
- Family history of familial polyposis
- Existing ulcerative colitis
- Crohn's disease
- Existing polyposis syndrome
- Increasing age (those over age 40 are at higher risk)
- Diet high in animal protein, fats, and refined carbohydrates like sugars
- Prior colorectal cancer

Self-Care and Prevention

Unlike many other cancers, there are several things one can do to help prevent colon cancer. The National Cancer Institute recommends the following to help prevent colon cancer:

- East fresh or dried fruits for desserts and snacks
- Include beans, legumes, and peas in soups, stews, casseroles, and salads

- East whole-grain cereals and breads. Eat brown rice and buckwheat instead of white rice and refined grains
- Increase fiber intake by leaving the skins on potatoes, fruits, and vegetables

In addition to the nutritional recommendations above, it is also recommended that one have screenings for colon cancer. Several early detection methods are available:

- Annual fecal test for blood in the stool, starting at age 50 (limited accuracy)
- Annual digital rectal examination, starting at age 50
- Sigmoidoscopy every five years, starting at age 50
- Colonoscopy every 10 years, starting at age 50 (more frequently for people with certain risk factors); or double contrast barium enema every 5 – 10 years, starting at age 50

The OSD Newsletter
(The Office for Students with Disabilities)

Ovarian Cancer

Description

Ovarian Cancer is the most lethal form of cancer in women, and the fifth most common type of cancer in women. Each year, nearly 30,000 new cases are diagnosed; one in 65 women will develop the disease by the age of 85. It most commonly affects women between the ages of 50 and 70. Nearly all ovarian cancers begin on the epithelium (the outer layer of the ovary). About 15% occur as borderline tumors, which have a better outlook because the tumors are less aggressive, 75% are classified as ovarian invasive epithelial carcinoma, and the remaining 10% occur equally in the germ cells (where eggs are produced) and the stroma (a fibrous network of tissue within the ovary). (www.planetrx.com)

Characteristics

- Fifth most common cause of cancer in women
- Most lethal form of cancer in women; causes the most deaths of all gynecological cancers
- Usually detected in advanced stage
- Few or no early warning signs or symptoms
- Family history is the greatest risk factor (however, fewer than 10% of women with ovarian cancer have a family history)

Symptoms

- Discomfort or pain in abdomen; feeling of pressure in pelvis
- Abdominal swelling, bloating, gas, or indigestion
- Unusual vaginal discharge or bleeding
- Change in bowel or bladder function (constipation, frequent urination)
- Weight loss
- General ill health
- Nausea
- Anemia
- Palpable mass in the abdomen or pelvic area
- Rarely, enlarged breasts and increased hair growth

Causes and Risk Factors

The cause of ovarian cancer is unknown, but hereditary factors are suspected to play a role in its development. There are several risk factors that increase the likelihood of developing ovarian cancer such as:

- Family history
- Age
- Having few or no children
- Delayed childbirth (after age 35)
- Use of fertility drugs to stimulate ovulation
- History of breast cancer or endometrial cancer
- Family history of Lynch II Syndrome (marked by high rates of cancers of the colon & uterus)
- Exposure to asbestos or high levels of radiation

Self-Care and Prevention

Though there are no general steps for preventing ovarian cancers, there are some measures that are thought to help protect against the disease or minimize its effects. Such measures are to:

- Eat a healthy diet
- Avoid contaminants such as asbestos and radiation
- Consider hormone treatment such as oral contraceptives
- Avoid alcohol
- Have regular examinations