

**CHAPTER 14**  
**TRANSPORTING STUDENTS**  
**WITH SPECIAL NEEDS**

## **TRANSPORTING STUDENTS WITH SPECIAL NEEDS**

### **LESSON TOPIC:**

### **TRANSPORTING STUDENTS WITH SPECIAL NEEDS**

### **OBJECTIVE:**

The driver will be able to:

- ❖ identify some physical characteristics and behavior tendencies of special needs students;
- ❖ describe loading/unloading procedures;
- ❖ describe student management techniques; and
- ❖ suggest ways to communicate with special needs students

**INTRODUCTION**

A school bus driver has a unique opportunity to provide a positive influence on the lives of special needs students as they are being transported. Many basic tasks of meeting personal care needs, communicating and socializing with others and physically moving from one (1) location to another are major accomplishments for these students. By providing an atmosphere of friendly assistance and responding to their individual and group needs, a driver is in a position to become an important link in their efforts to reach their achievement potential.

The success of a program for exceptional children depends upon the people who have daily contact with the children. They should be patient, alert, flexible, resourceful, enthusiastic, emotionally stable, have personal warmth, friendliness, understanding and compassion. A bus driver should be able to develop and maintain rapport with children and be able to exercise mature judgement in relation to both the care of exceptional children and the responsibilities of driving.

A driver should be able to accept this child and his/her problems as he/she would accept any child. These children should be treated as a person would treat their own children with special needs.

The daily bus ride to school can be an important part of the child's progress toward accomplishment of his/her goals. The child will learn how to leave home to meet the

bus. The bus rules should be explained and the child will learn to obey them. The bus ride to and from school can be a pleasant experience which a child anticipates eagerly, or it can become a dreaded experience. The driver should be thoughtful and careful about such routine matters as assigning a seat or seatmate, the presentation and purpose of a seatbelt and student management.

The driver of special needs students has many areas that are unique to his/her bus and their students, which the regular drivers do not have.

Following are some ideas that could be helpful to the driver in these special areas. They are given only as suggestions and ideas.

**REMEMBER:**

1. Be firm – but gentle.
2. Be patient – but persistent.
3. Always be consistent and fair.

The driver's primary purpose is to take children to and from school safely and dependably. While allowances are made for specific problems of these students, a child's social adjustment should be of less importance than getting to school on time and the safety of the bus, driver and other children.

**COMMUNICATIONS**

The driver should know about the needs and abilities of the passengers, and the best way to learn these is through communication with school staff.

**PARENT – DRIVER**

With the school's permission, drivers and parents should discuss safety rules on the bus, special equipment use, schedules and transporting medication as various needs require various plans.

**LIFTING AND/OR CARRYING STUDENTS**

There are several safe and effective ways to lift a child. The driver will be able to learn these techniques by conversation and application with school specialists. These techniques will vary depending on each child's needs.

**SPECIAL EQUIPMENT**

Following are recommendations for special needs students:

1. Due to varied disabling conditions, all seats have rolled padded tops and sides to help reduce chances of pupil injury on panic stops. Foam seats provide more secure seating. Modesty panels and stanchion posts should be added.
2. Seatbelts on school buses are recommended for the safety of all special needs students.

**DRIVER QUALIFICATIONS**

Besides operator qualifications regarding age, health, past experience, knowledge of vehicles and maintenance, safe driving practices, etc.; a driver should be able to operate specially equipped or adapted vehicles. The

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	<p>driver should become familiar with the use of wheelchairs, braces, crutches, etc.</p> <p><b><u>MEDICAL NEEDS</u></b></p> <p style="text-align: center;"><b>INFORMATION</b></p> <p>The driver should be aware of the problems of each of the students who ride the bus. He/she should be familiar with the medical and physical aspects of disabilities of each child. He/she should, through communication with school personnel and parents, know when a child is on medication and the effects of that medication. This will help him/her to determine when a child is behaving accordingly.</p> <p>The driver has the responsibility of reporting to school authorities or to parents specific incidents, attitudes, etc., which may be significant in the treatment of the child. He/she should know what special steps to take in case of a traffic incident or breakdown because the comfort and emotional well-being of these children is the driver's responsibility. He/she may spend much time learning how to care for each child under the many circumstances that might occur while the children are on the bus.</p> <p><b><u>SEIZURE MANAGEMENT</u></b></p> <p style="text-align: center;"><b>TO PREVENT INJURY TO THE CHILD</b></p> <ol style="list-style-type: none"> <li>1. Observe the progression of symptoms during the seizure. Note the:       <ol style="list-style-type: none"> <li>a. first thing the child does in an attack, in regard to movements;</li> </ol> </li> </ol>

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- b. types of movements of the part involved (stiffness starts, position of eyeballs and head);
  - c. body parts involved;
  - d. size of the pupils;
  - e. incontinence of urine and feces;
  - f. duration of each phase of the attack;
  - g. unconsciousness, if present, and its duration;
  - h. any obvious paralysis or weakness of arms or legs after the attack;
  - i. inability to speak after the attack; and
  - j. whether or not the child sleeps after the attack.
2. Support the child during the convulsive seizure.
- a. Ensure the child has adequate airway.
  - b. Give the child privacy and protection from curious on-lookers.
  - c. Protect the head with padding to prevent head injury.
    - Towels, blankets, coats, clothes or book bags can be used.
    - Loosen constrictive clothing.
    - Provide protection with the possibility of suffocation.

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	<p>d. When jaws are clenched in spasm DO NOT attempt to pry open to insert a mouth gag.</p> <p>e. Place child on his/her side during convulsion (if possible) to facilitate drainage of mucus and saliva. Do not attempt to lift child during the seizure; to do so may cause injury. Instead of moving the child during a seizure, remove things that could cause injury.</p> <p>f. Once convulsive movements have stopped, allow the child to recover naturally. When appropriate (when the child awakens), reorient the child to his/her environment.</p> <p><b>TYPES OF SEIZURES AND THEIR CLINICAL MANIFESTATIONS</b></p> <p>1. AURA</p> <p>a. Small localized seizures that sometimes precede grand mal seizures and act as a warning.</p> <p>b. The child cannot explain them but knows they exist.</p> <p>c. May include vague symptoms such as irritability, headache, gastrointestinal disturbances or mental dullness.</p>

- d. The interval between the aura and grand mal seizure is usually short, but it may be an hour or more than a day.
2. GRAND MAL
- a. Onset
- Onset is abrupt.
  - May occur at night.
  - An aura occurs in about one-third of epileptic children prior to a grand mal seizure.
- b. Tonic Spasm
- The child's entire body becomes stiff.
  - The child usually loses consciousness.
  - The face may become pale and distorted.
  - The eyes are frequently fixed in one position.
  - The back may be arched with the head held backward or to one side.
  - The arms are usually flexed with the hands clenched.
  - The child may bite his/her tongue or cheek. (This occurs because of a sudden forceful contraction of jaw and abdominal muscles.)
  - The child is often unable to swallow his/her saliva.

- Breathing is ineffective and cyanosis (turning blue) results if spasm includes the muscles of respiration.
  - The pulse may become weak and irregular.
  - c. Clonic Phase
    - This phase is characterized by twitching movements that follow the tonic state.
    - Phase usually starts in one place and becomes generalized, including the muscles of the face.
  - d. Duration
    - Length varies.
    - Usually, convulsions cease after a few minutes and consciousness returns.
  - e. Post-Convulsive State of Child
    - The child is usually sleepy or exhausted.
    - May complain of headache.
    - May appear to be in a dazed state.
    - Often performs relatively automatic tasks without being able to recall the episode.
3. PETIT MAL
- a. Petit mal onset rarely appears before three (3) years of age.
  - b. Clinical Signs

- Loss of contact with the environment for a few brief seconds. May appear to be staring or daydreaming and will suddenly discontinue any activity and resume it when the seizure has ended.
  - Minor manifestations include rolling of the eyes, nodding of the head and slight quivering of the trunk and limb muscles.
- c. Duration is usually less than thirty (30) seconds.
- d. Frequency varies from one to two per month to several hundred each day.
- e. Post convulsive state of child:
- appears normal; and
  - the child is not aware of having had a convulsion.
4. FOCAL SEIZURES (PSYCHOMOTOR)
- a. Clinical Signs
- ✓ Child undertakes purposeful but inappropriate motor acts.
  - ✓ Child may pick at clothing with hands.
  - ✓ Child may make chewing movements with mouth or perform other complicated actions.

- ✓ A young child may emit a shrill cry or attempt to run for help. There is usually a gradual loss of postural tone.
- ✓ May have pallor around mouth.
- b. Duration is brief, usually about one (1) minute.
- c. Post-Convulsive State of Child
  - Child may be confused after an attack, but has no “memory of what happened.”
- 5. FOCAL MOTOR (JACKSONIAN SEIZURES)
  - a. Clinical Signs
    - Sudden jerking movements occur in a particular area of the body such as the face, arms or tongue (less often the leg or foot).
    - Seizure begins on one (1) side of the body and spreads to adjacent areas on the same side in a fixed progression.
    - Prognosis: seizure may become more extensive as the child matures, leading to grand mal seizures.
  - b. Focal Sensory (rare in children)
    - Sensations may occur, such as numbness, tingling and coldness.

**TO OBSERVE THE CHILD FOR RECURRENT SEIZURES:**

1. Place the child where he/she can be watched closely.
2. Check child frequently. Watch for and report to school or parent(s) /guardian(s) if you see:
  - behavior changes;
  - irritability;
  - restlessness; and/or
  - listlessness.

**CARE DURING A SEIZURE:**

1. Maintain patient airway and adequate ventilation. Loosen tight clothing (belt, collar, etc.); turn child onto side to facilitate drainage, or turn head to the side and point chin downward. This allows saliva and mucus to run out of the mouth and not be aspirated; the tongue will drop forward away from airway. During convulsions, the child is unable to swallow. This increases the possibility of aspiration because vomitus and increased secretions are frequently present.
2. Do not attempt to forcibly open convulsing child's mouth if the jaws are clenched.
3. Do not attempt to push an airway or tongue blade forcibly between front teeth. To do so may break or loosen teeth or injure lips.

4. Never put your fingers into the child's mouth; the child may accidentally bite you during the seizure.
5. Do not attempt to restrain the child's movements during convulsions. Restraint may increase the movements and their severity and could cause fracture if extreme spasticity is present. Lightly hold the child's hands to prevent him/her from banging them.

**DEFINITIONS AND DESCRIPTIONS**

1. Physically Disabled Or Orthopedically Impaired
  - a. Severe orthopedic impairment which adversely affects educational performance to the extent that specially designed instruction is required for the pupil to benefit from education.
  - b. These students have a range of physical or health problems. Some are able to work full-time in the general (comprehensive) education program and need only special transportation and an architecturally accessible building. They are taught to lead productive, independent lives by learning to compensate for their physical disabilities.

2. Other Health Impaired
  - a. Limited strength, vitality or alertness, due to a chronic or acute health problem, which adversely affects educational performance to the extent that specially designed instruction is required for the pupil to benefit from education.
  - b. These students are medically fragile and/or chronically ill and need the environment of a special classroom. They are taught to compensate for their physical disabilities to the extent possible in order to lead productive, independent lives.
3. Communication Disorder – Speech/Language Impaired
  - a. Disorder in language, articulation, voice or fluency, which adversely affects educational performance that specially designed instruction is required for the pupil to benefit from education.
  - b. The student may have any or all of the following problems: does not pronounce words clearly, stutters, does not understand what people say to him/her, and/or is unable to put his/her thought into words.

4. Hearing Impairment
  - a. Physiological hearing loss ranging from mild to profound, permanent or fluctuating, and of such a degree that the pupil is impaired in the processing of linguistic information via the auditory channel either with or without amplification, adversely affecting educational performance so that specially designed instruction is required for the pupil to benefit from education.
  - b. These students have a range of hearing loss from mild to profound. All of them are encouraged to communicate through speech that is somewhat difficult to understand. They are also expected to speech read (“read lips”) as much as possible so that they will be able to communicate with non-handicapped persons. Some students supplement their speech with various types of manual (hand) signing. It is easier for them to speech read if the person is facing them and speaks at a normal (not slowed) rate. (A mustache/beard sometimes makes speech reading more difficult.) Many hearing impaired students have some

speech, but have difficulty discriminating between speech and background noises. Almost all hearing impaired students have hearing aids and should be encouraged to wear/use them at all times.

5. Mental Disability

- a. Deficit or delay in intellectual or adaptive behavior functioning, which adversely affects educational performance so that specially designed instruction is required for the pupil to benefit from education.
- b. Individual intellectual assessment reflects:
  - Educable Mentally Handicapped (EMH, 75-50 IQ). These students are mildly mentally disabled. As adults, many may be successfully employed and live independently. They learn best when provided with very clear, specific directions and much repetition. They tend to follow the leadership of others (adults or fellow students) but have difficulty discriminating whether or not that leadership is appropriate.

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	<ul style="list-style-type: none"> <li data-bbox="925 189 1494 861">➤ Trainable Mentally Handicapped (TMH, 50-35 IQ). These students are moderately mentally disabled. As adults, they may be employable and may experience independent living. Many TMH students have impaired motor skills and move more slowly and awkwardly than do non-handicapped students. They are generally willing and able to follow directions that are given in simple terms.</li> <li data-bbox="925 892 1494 1816">➤ Severely/Profoundly Handicapped (SPH, Below 35 IQ). These students are severely mentally disabled and frequently have physically disabilities as well. They will benefit from inclusion in social activities and other learning experiences with non-handicapped persons. A major goal is to teach them to be as independent as possible, using whatever language and motor skills they have in order to care for their own needs and interests with others. As adults, while gainful employment and independent living are possible, self care is anticipated.</li> </ul>

6. Emotional-Behavioral Disability
  - a. Behavioral excess or deficit, which significantly interferes with a pupil's interpersonal relationships or learning process to the extent that it adversely affects educational performance so that specially designed instruction is required.
  - b. The major problems these students have are usually those of controlling their own behavior and interacting appropriately with adults and peers. They may over-react to apparent trivial situations. They may also be defiant of authority – especially in front of their peers. They may “test” an adult to find out if misbehavior will be tolerated. They need to be given – before an incident occurs – very specific directions as to what is expected of them. It is helpful to establish a few rules. It is better to state rules in terms of what they should do (e.g., “Keep your hands inside the bus.”) rather than what they should not do (e.g., “Do not put your hands outside the bus.”) Do not make idle threats; if consequences have been previously established for a specific misbehavior, they must be capable of being carried out. Some students are on a

behavior management program and are rewarded when the bus driver reports to the teacher that their bus behavior has been acceptable.

7. Multiple Disability

- a. A combination of two (2) or more disabilities resulting in significant learning, developmental or behavioral and emotional problems. Adversely affect educational performance to the extent that specially designed instruction is required for the pupil to benefit from education.
- b. Students in this category have a combination of two (2) or more handicapping conditions – physical and/or mental. The students within this category do not all have similar needs. Their programs are specially designed to match their needs and abilities.

8. Specific Learning Disability

Disorder in one (1) or more of the psychological processes. Primarily involved in understanding or using spoken or written language which selectively and significantly interferes with the acquisition, integration or application of listening, speaking, reading, writing, reasoning or mathematical abilities.

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- This disorder is life long. Intrinsic to the individual, it adversely affects educational performance to the extent that specially designed instruction is required for the pupil to benefit from education.
- This term does not include a learning problem which is a direct result of a hearing impairment; visual, physical, mental or emotional-behavioral disabilities or environmental, cultural or economic differences.

These students have difficulties in one (1) or more specific areas, such as motor skills or reading, writing, or mathematics. Their problems are mostly academic, but sometimes their frustration with avoidance of academic tasks can result in mild behavior problems. These students tend to learn each thing in isolation, rather than applying their knowledge to many situations, and the students tend to act on impulse without considering the consequences.

## 9. Visually Disabled

- a. Visual impairment which, even with correction, adversely affects educational performance to the extent that specially designed instruction is required for the pupil to benefit from education.
- b. Very few of these students are totally blind. Most have some usable vision and can see shapes, shadows and other clues that help them to move through their surroundings. They are taught to use their senses of touch and hearing to provide the additional information they do not receive with their eyes. While some read Braille materials, most can use large print textbooks or other enlarging devices.

## 10. Traumatic Brain Injury

- a. Acquired impairment to the neurological system resulting from an injury to the brain, which adversely affects educational performance to the extent that specially designed instruction is required for the pupil to benefit from education.
  - Does not include a brain injury that is congenital or degenerative, or a brain injury induced by birth trauma.

- b. These students have experienced some injury to the brain and exhibit a wide range of mental and physical abilities. These students will have shorter attention span, short-term memory loss or lack of concentration. Mild behavior problems may result. Due to the nature of the injury, students have individual needs.

#### 11. Autism

- a. Developmental disability significantly affecting verbal and non-verbal communication and social interaction, generally evident before age three (3) that adversely affects education performance to the extent that specially designed instruction is required for the pupil to benefit from education. Characteristics include:
- irregularity and impairment in communication;
  - engagement in repetitive activity and stereotyped movement;
  - resistance to environmental change or change in daily routine; and/or
  - unusual responses to sensory experiences.

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	<p>This does not include children with characteristics of an emotional-behavioral disability.</p> <p>b. The student displaying “autistic” or “autistic-like” behaviors may have difficulty developing and using verbal or nonverbal communication systems making it difficult to use traditional methods of interaction. The student may engage in repetitive motions or behavioral patterns and perhaps will be sensitive to being touched. Specific behavior modification techniques are needed to elicit the most correct behavior, making it important for the transportation staff to conference with the student’s teacher regarding appropriate interventions.</p> <p><b><u>BEHAVIOR PATTERNS</u></b></p> <p>Behavior patterns of each child are individual problems and should be understood. Each driver must treat each child separately. For example, don’t give a general direction to the entire busload of children. You can’t assume everyone would understand this direction.</p> <p>Behavior patterns of these children for any given day or hour of the day can be caused or changed by the actions of many people:</p>

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1. you, the school bus driver;
2. parents, or members of the family;
3. teacher or aide; and/or
4. other bus passengers.

These people affect any child, but they can compound the trouble that a special needs child may already have.

The person managing the student can understand what may have caused the problem and be able to correct it.

When you correct a child, regardless of the age and size of him/her, take into consideration his/her attention span. With some children, this can be rather short. Be consistent when you correct a child.

A student may behave differently from day to day because of medication, which he/she may be taking. Many students are extremely hyperactive and use their excessive energy to get attention from you or from someone else.

It is difficult to give guidelines for handling all situations. Following are some courses of action that should prove helpful:

1. Work with school specialist by talking over any problems.
2. Work with the teachers.
3. Work with the parents.
4. Work with the child.

It can also be of help to move the child to another seat away from a student who may be causing problems.

**EDUCATIONALLY HANDICAPPED CHILDREN**  
**IN TRANSPORT**

Maintain a set of clear-cut rules. Make a short list of rules concerning behavior while riding the bus and following them to the letter. The child wants to know where he/she stands at all times. Remember, once children begin to misbehave, they may not be able to help themselves – you must help them. Any deviation from these rules will only confuse the child. Be firm, but fair, smile often for this child, but be direct when you address him/her. You could be the key to the pupils' whole day! You are the first school authority to see them in the morning and the last to see them at night. Say "Good morning" and let them know that you are glad to see them and want them to ride on your bus. (This will be difficult at times, but it will pay off in the long run.) If a child is on a medication, you must know the effects of the medication and what to do if it should wear off.

You must be resourceful in discipline areas.

**LOADING AND UNLOADING**

Most transportation systems, when possible, load and unload special education children in front of each child's home due to the fact that the child cannot be left unattended.

These children sometimes need assistance to board the bus. Eye-to-eye contact with some children is a must. Most buses used for this purpose are equipped with safety devices (harnesses, etc.), which should be used.

Care is needed at all times to keep these children on the bus when other children are being loaded or unloaded.

A child who must use special equipment such as a wheelchair, braces, crutches, etc., has problems during the loading and unloading process, and it is your responsibility to learn these problems and know how to correct them.

Remember, care and protection are two (2) things which the parents and children expect from a driver.

Usually, you will follow the same loading and unloading procedures for controlling the bus as you would when transporting regular passengers.

**PROCEDURE FOR OPERATING SOME LIFT  
EQUIPMENT**

1. Bus must be in neutral, emergency brake on.
2. Open lift doors and hook latches in outside wall of bus.
3. Remove hand-held controls and push long lever down to unfold platform (platform will be flush with floor of bus).
4. Press "lower platform" button.
5. Lower platform to ground level (make sure hinge releases barrier).
6. Roll wheelchair backwards and lock hand brakes.
7. Place hand on wheelchair to give the student secure feeling.

8. Press “raise platform” button, making sure barrier locks in place. (Platform will raise to bus floor level.)
9. Pull wheelchair into bus and secure.
10. Fold platform back into bus and shut doors.
11. No one may ride on the lift with a student.  
Then follow these steps:

**IF AN AIDE IS ASSIGNED TO THE BUS**

1. Be sure each person knows his/her role. In the case of misunderstanding, don’t argue. Carry on any discussion out of the student’s presence.
2. Direct the aide to carry or guide the student onto the bus.
3. When the use of assistive devices are required, check to see that they are securely fastened before putting bus into motion.
4. When specially equipped buses are used to accommodate wheelchairs, etc., with the use of a ramp or lift, supervise the aide in guiding chair onto bus and securing it in place inside the bus.
5. When loading or unloading, the driver must be on the bus.
6. Check to see that the ramp and side door have been securely fastened into a locked position after the student has entered the bus. Start the bus and follow procedure for entering the flow of traffic.

**IF AN AIDE IS NOT USED:**

1. Set the parking brake, secure the bus in “park,” turn off the motor and take the key out of the ignition.
2. Leave the bus and carry or guide the handicapped student onto the bus. (The student should be brought to the bus by a parent or other responsible person.)
3. Check to see that the ramp and side door have been securely fastened into a locked position after the student has entered the bus. Start the bus and follow proper procedure for entering the flow of traffic.

**UNLOADING ON SCHOOL GROUNDS:**

1. Carry or guide, each student off the bus into the charge of a teacher or other school attendant.
2. Check to see that all belongings of each student are taken off the bus.

**UNLOADING THE PASSENGER AT HOME:**

1. Carry, or guide, each student off the bus into the charge of a parent or other responsible person.
2. Check to see that all belongings of each student are taken off the bus.
3. Report tactfully to the parent and school officials any observation, which may be inappropriate, whether medical or behavioral.

4. If an authorized person is not at home to receive the student, follow local procedures.

**DUTIES****ON THE ROAD**

1. Assign the bus aid to ensure that all passengers remain safely seated. Occasionally a particular student's needs require more than you can provide as one who must be responsible for the safety of all passengers. Do not allow students to continually demand your attention when you are driving.
2. If any students show symptoms of illness that require immediate attention, pull the bus as far off of the road as possible and stop; activate four-way hazards lights.
  - a. If a radio is available, notify the proper authorities; otherwise, notify the aide or passing motorist to call authorities from a phone booth or nearby private home.
  - b. Watch for unusual behavior that may occur; for example, petit mal or grand mal seizures, erratic behavior or inactivity, etc.

**GETTING THE FACTS**

A driver must have pertinent information about each of the passengers and be a special observer of behavior on the bus. A driver is often the source of information, which is vitally important to the supervisor, the student's teacher and parents. Some passengers will have medical

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medical instructions specifying special care or medication limitations. Secure pertinent information about each student transported. Make a confidential card file form to be kept on the bus and in your supervisor's office. A 3" X 5" card is suggested. See below:

	Name:
	Address:
	Telephone#:
	Emergency Back Up #:
	Birthdate:
Parents:	
Medication:	
Hospital:	
Doctor:	
Doctor Phone #:	
Insurance:	
Special Instructions:	
Map where child lives may be put on back.	

**SUPPLEMENTAL RESOURCES:**

"The Special Needs Pupil Transportation Series", video, AMS Distributors, Inc., Roswell, GA

"A Video Training Program on School Bus Evacuation", video, Monroe Boces #1, Fairport, NY, 1991.

"Every Student I Have Ever Driven – Evacuation All Students From Your School Bus." Manual, Monroe Boces #1, Fairport, NY 1991.

"School Bus Driver Program: Pupils Are Different", film, Aetna Life and Casualty.

"Problems in Transporting the Handicapped", film, Visucom Products, Inc., Redwood City, CA.

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**TRANSPORTING STUDENTS WITH SPECIAL NEEDS**  
**TEST**

**\*\*PLEASE ANSWER TRUE OR FALSE\*\***

1. \_\_\_\_\_ The driver cannot be expected to accept a special needs child as he/she would any child, since the child has obvious differences.
2. \_\_\_\_\_ The driver of a special needs bus should be fair, firm and consistent when dealing with pupil behavior management.
3. \_\_\_\_\_ There is a law that requires seat belts on special needs buses.
4. \_\_\_\_\_ Two types of seizures are aura and clonic spasms.
5. \_\_\_\_\_ During a tonic spasm seizure, a victim usually remains conscious.
6. \_\_\_\_\_ A petit mal seizure usually lasts less than thirty (30) seconds.
7. \_\_\_\_\_ An EMH student has an IQ in the 75-50 range.
8. \_\_\_\_\_ When dealing with special needs students, it is almost impossible to have a set of clear-cut rules for the entire bus.
9. \_\_\_\_\_ Two things that the parents and children expect from the driver when loading and unloading is care and protection.
10. \_\_\_\_\_ Any misunderstanding between the driver and the aide should be dealt with immediately at all times, so as to keep the lines of communication open.

INSTRUCTOR'S SIGNATURE: \_\_\_\_\_

**TRANSPORTING STUDENTS WITH SPECIAL NEEDS**  
**TEST**

**\*\*PLEASE ANSWER TRUE OR FALSE\*\***

**KEY**

The answer key is only released to KDE endorsed trainers.