

## Occupational Therapy Services in Early Childhood and School-Based Settings

The primary purpose of this document is to describe how occupational therapy supports children's and youth's learning and development in early childhood and school-based settings. This document is intended for occupational therapists and occupational therapy assistants in practice, academia, research, advocacy, and administrative positions. Other audiences for this statement include regulatory and policymaking bodies, provider groups, accreditation agencies, other professionals, and the general public who may be seeking clarification about occupational therapy's scope of practice and domain of concern related to this topic. The American Occupational Therapy Association (AOTA) provides information and resources to support occupational therapists and occupational therapy assistants in the delivery of effective services for children and youth in a variety of settings, including school-based and early intervention programs, child care, Head Start and Early Head Start, preschool and pre-kindergarten programs, and at home.

Occupational therapists and occupational therapy assistants<sup>1</sup> work with children and youth, parents, caregivers, educators, and other team members to facilitate children's and youth's ability to participate in everyday activities, or *occupations*. Occupations are "activities...of everyday life, named, organized, and given value and meaning by individuals and a culture" (Law, Polatajko, Baptiste, & Townsend, 1997, p. 34). Occupations are meaningful for the child and are based on social or cultural expectations or peer performance. In early childhood (birth–8 years of age) and school-based settings, occupational therapy practitioners<sup>2</sup> use their unique expertise to help children and youth with and without challenges prepare for and perform important learning and developmental activities within their natural environment. Occupational therapy services support a child's participation in activities of daily living (ADLs), instrumental activities of daily living (IADLs), education, work, play, leisure, rest and sleep, and social participation.

Occupational therapists have knowledge and skills in the biological, physical, social, and behavioral sciences to evaluate and intervene with individuals across the life course. Occupational therapy practitioners apply evidence-based research ethically and appropriately to the evaluation and intervention process following professional *Standards of Practice* (AOTA, 2010b) and the *Occupational Therapy Code of Ethics and Ethics Standards* (AOTA, 2010a).

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<sup>1</sup>*Occupational therapists* are responsible for all aspects of occupational therapy service delivery and are accountable for the safety and effectiveness of the occupational therapy service delivery process. *Occupational therapy assistants* deliver occupational therapy services under the supervision of and in partnership with an occupational therapist (AOTA, 2009).

<sup>2</sup>When the term *occupational therapy practitioner* is used in this document, it refers to both occupational therapists and occupational therapy assistants (AOTA, 2006).

## Legislative Influences on Service Delivery

Occupational therapy practice in schools and early childhood settings is affected by many federal and state laws and regulations, as well as local policies and procedures. Table 1 summarizes some of the policies that directly affect the provision of occupational therapy for children and youth. Additional information about these laws is provided in *Occupational Therapy Services for Children and Youth Under IDEA* (Jackson, 2007).

AOTA believes that occupational therapy practitioners working in early childhood and school settings should have working knowledge of the federal and state requirements to ensure that their program policies are in compliance. Occupational therapy practitioners also should be familiar with their state’s occupational therapy practice act and related rules and regulations to ensure that occupational therapy services are provided accordingly.

**Table 1. Federal Laws and Their Influence on Occupational Therapy Services**

Law	Influence on Occupational Therapy Services
Individuals with Disabilities Education Improvement Act (IDEA), P.L. 108-446	Federal legislation that specifically includes occupational therapy as a related service for eligible students with disabilities, ages 3–21 years, to benefit from special education (Part B) or as a primary service for infants and toddlers who are experiencing developmental delays (Part C).  IDEA may be reauthorized and amended in 2011.
Elementary and Secondary Education Act (ESEA) Amendments, No Child Left Behind Act (NCLB), P.L. 107-110	Federal legislation that requires public schools to raise the educational achievement of all students, particularly those from disadvantaged backgrounds, students with disabilities, and those with limited English proficiency, and that states establish high standards for teaching and student learning. While not specifically mentioned in the statute, occupational therapy is generally considered to be a pupil service under ESEA.  ESEA may be reauthorized and amended in 2011.
Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. 794; Americans with Disabilities Act (ADA, as amended); Americans with Disabilities Act Amendments Act of 2008 (ADAAA), P.L. 110-325	Civil rights statutes that prohibit discrimination on the basis of disability by programs receiving federal funds (Section 504) and by services and activities of state and local government (ADA and ADAAA). Disability here is defined more broadly than in IDEA. Children and youth who are not eligible for IDEA may be eligible for services under Section 504 or the ADA, such as for environmental adaptations and other reasonable accommodations, to help them access and succeed in the learning environment. Each state or local education agency determines eligibility procedures for children and youth served under Section 504 or the ADA.
Title XIX of the Social Security Act of 1965, as amended; Medicaid, P. L. 89-97	Federal–state match program that provides medical and health services for low-income children and adults. Occupational therapy is an optional service under the state plan but mandatory for children and youth under the Early Periodic Screening, Diagnosis and Treatment (EPSDT) services mandate.

	Occupational therapy services provided in early intervention programs are frequently covered by Medicaid. School-based services also may be covered by Medicaid but also must meet applicable medical necessary requirements as well as be educationally relevant.
Improving Head Start for School Readiness Act of 2007, P.L. 110-134	Federal program that provides comprehensive child development services to economically disadvantaged children (ages birth–5 years) and their families, including children with disabilities. Early Head Start serves children up to 3 years of age. Occupational therapy may be provided in these settings under the Head Start requirements or under IDEA.
Assistive Technology Act of 2004, P.L. 108-364, as amended	Federal program that promotes access to assistive technology for persons with disabilities so that they can more fully participate in education, employment, and daily activities.
U.S. Department of Agriculture Food and Nutrition Service (USDA, 2001)	National School Breakfast and Lunch Programs are required to provide food substitutions and modifications of school meals for students whose disabilities restrict their diets, as determined by a doctor.

## Occupational Therapy Domain and Process

Occupational therapy supports client health and participation in life through engagement in occupations (AOTA, 2008). Occupational therapy focuses on the following occupations: ADLs, IADLs, education, leisure, play, social participation, work, and rest and sleep.

Occupational therapy practitioners provide services that enable children and youth to organize, manage, and perform their daily life occupations and activities. For example, a middle-school-age child with physical limitations may have difficulty completing written work. The occupational therapy practitioner collaborates with the student, parents, and educators to identify the skills of the student, the demands of the environment, and appropriate solutions for interventions. Another example is the family of a newborn baby with poor feeding skills. The occupational therapist may provide training and support for the family to enhance the baby’s ability to drink from a bottle.

In early childhood and school-based practice, occupational therapy clients include individuals (e.g., child, family, caregivers, teachers), organizations (e.g., school districts, community preschools, Head Start), and populations within a community (e.g., homeless children, children at risk for social–emotional difficulties). Occupational therapy services are directed toward facilitating the client’s participation in meaningful occupations that are desired and important in the school, family, and community contexts.

Occupational therapy services include evaluation, intervention, and documenting outcomes. During the evaluation, the occupational therapist gains an understanding of the client’s priorities and his or her problems when engaging in occupations and activities. Evaluation and intervention address factors that influence occupational performance, including

- Performance skills (e.g., motor and praxis skills, sensory–perceptual skills, emotional regulation skills, cognitive skills, communication and social skills);
- Performance patterns (e.g., as habits, routines, rituals, roles);
- Contexts and environments (e.g., physical, social, cultural, virtual, personal, temporal);
- Activity demands (e.g., required actions, body functions); and
- Client factors (e.g., values and beliefs; mental, neuromuscular, sensory, visual, perceptual, digestive, cardiovascular, and integumentary functions and structures).

Desired outcomes are identified to guide future actions with the client. They also are a means for evaluating the effectiveness of occupational therapy services.

## **Occupational Therapy Service Provision**

Occupational therapy practitioners provide early childhood services in children’s homes, child care centers, preschools, Early and Head Start programs, early intervention programs, and clinical settings. Occupational therapy practitioners provide school-based services in both public and private facilities. Funding sources for occupational therapy services vary and may include federal and state funding (e.g., funding through state agencies, Medicaid), insurance, and self-pay.

Children and adolescents may be served under the Individuals with Disabilities Education Act (IDEA) Part C, if they are ages 3 years or younger, or Part B, if they are between the ages of 3 and 21 years. Some states are extending their Part C program to include preschool-age children.

### *Early Intervention (IDEA Part C; Birth Through Age 2 Years)*

Early intervention occupational therapy services are provided to infants and toddlers with developmental delays, with diagnosed physical or mental conditions, or who are at risk for having a developmental delay in order to enhance the family’s ability to care for their child with a disability. To be eligible for early intervention services under Part C, a child must have a delay in one or more of five developmental areas: (1) physical (including vision and hearing), (2) cognitive, (3) communication, (4) social–emotional, and (5) adaptive. When evaluating infants or toddlers, the occupational therapist considers aspects of the child’s performance that are strengths or barriers to participation within the natural environment and daily routines. The occupational therapist’s knowledge of brain development, assessment, and intervention across developmental domains, early literacy, and feeding/eating skills enables them to work with children with disabilities and their families. Infants and toddlers with significant medical or developmental concerns (e.g, feeding, neurological) should receive services from trained professionals, as they are vulnerable and require ongoing evaluation.

IDEA requires that child and family outcomes and services be developed in collaboration with the child’s caregivers, other members of the team, and community agencies. These services become part of the individualized family service plan (IFSP). Some examples of occupational therapy services for the five developmental domains are listed in Table 2.

**Table 2. Occupational Therapy’s Role in Early Intervention Developmental Areas**

<b>Developmental Area</b>	<b>Occupational Therapy’s Role</b>
Adaptive	Promote independence in self-care, such as eating and drinking, dressing, and grooming; collaborate with parents about safe positioning and modification of food textures to enhance eating
Cognitive	Promote ability to notice and attend to objects and people in the environment; promote ability to sort and classify objects and to generalize learning to new daily living tasks; promote ability to sequence steps to complete daily living occupations
Communication	Facilitate language development through social interactions, assistive communication devices, switches, toys
Physical	Promote movement for exploration of the environment, facilitate use of arms and hands to handle and manipulate objects, educate caregivers in handling and positioning techniques
Social–emotional	Foster self-regulation, social participation, and play through interactions with peers and adults

In Part C programs, occupational therapy is a primary service. The occupational therapist may be the sole service provider but most often is part of a collaborative team that works to enhance the family’s capacity to care for the child’s health and development within daily routines and natural environments. An occupational therapist may serve as the service coordinator to monitor the implementation of the IFSP and coordinate services with other team members and agencies. When the child is turning 3 years of age, the occupational therapist works collaboratively with the IFSP team to transition children to appropriate community-based programs or to preschool special education services, as applicable.

*School Age (IDEA Part B; Ages 3–21 Years)*

The local school district is responsible for determining whether school-age children and youth with disabilities, including preschool children from ages 3 to 5 years, qualify for special education and related services under IDEA Part B (§602(3)(A)(ii)). A full and individual evaluation is conducted, and an individualized education program (IEP) is developed if the student is eligible for services. Students with disabilities may be eligible for IDEA if they meet one or more of 10 disability categories:

1. Mental retardation;
2. Hearing impairments, including deafness;
3. Speech or language impairments;
4. Visual impairments, including blindness;
5. Serious emotional disturbance;
6. Orthopedic impairment;
7. Autism;
8. Traumatic brain injury;

9. Other health impairment; or
10. Specific learning disabilities (see §602(3)(A)).

Occupational therapy is one of the related services that may be provided to IDEA-eligible students who are receiving special education in schools; homes; hospitals; and other settings, including juvenile justice and alternative education settings. Related services are “transportation, and such developmental, corrective, and other supportive services (including...occupational therapy)...as may be required to assist a child with a disability to benefit from special education, and includes early identification and assessment of disabling conditions in children” (see §602(26)(A)). As such, occupational therapy is a support service for students and teachers.

When an occupational therapy evaluation is required, data collection is focused on identifying the academic, developmental, and functional needs of the student (see §614(d)(3)(A)(iv)). Information is sought regarding the student’s strengths and factors that may be interfering with his or her learning and participation in the context of the educational activities, routines, and environments. Observations are made where and when difficulties occur at school (i.e., at the times and in the location in which the student normally engages in the activities and is demonstrating behaviors that are of concern). These locations include the classroom, hallways, cafeteria, restrooms, gym, and playground. The student’s work, participation, and behaviors are compared with other students in the same environments and situations. Curricular demands and existing task and environmental modifications are reviewed.

Interviews with instructional personnel, the student, and family members are conducted to gather information about the student’s participation and performance. Cultural differences that may exist between home and school are explored. Existing special education supports and services, including strategies utilized to improve performance, are reviewed. Practices consistent with universal design for learning (UDL) guidelines (CAST, 2008) and the availability of assistive technologies to support school performance are assessed. Standardized testing may be conducted when needed to gather additional data.

Occupational therapy evaluation results then are shared with the parents and the multidisciplinary IEP team. According to Nolet and McLaughlin (2005), decisions about an IEP are individualized but “start from the expectation that the student is to learn the general education curriculum, and special education’s role is to help the student learn and progress in that curriculum” (p. 14). Annual goals for special education instruction are determined by the IEP team, as well as the accommodations and services and supports required to help the student access and progress in the general curriculum. Occupational therapy practitioners collaborate with the IEP team regarding the educational need for occupational therapy services.

On the basis of current occupational therapy evaluation data; the occupational therapist’s professional judgment; and other available information about the student’s skills, abilities, goals, and objectives to be achieved, the IEP team decides whether occupational therapy services are needed. The development of the IEP is a collaborative process with participation from all team members. The team determines when the student goals need the expertise of an occupational therapy practitioner, as well as the amount of time, frequency, duration, and location of those services. The team meets regularly (at least annually) to assess whether the student is making

progress toward achieving his or her goals and whether special education and/or related services (including occupational therapy) need to be continued, modified, or discontinued.

Intervention can be directed toward individuals (including teachers and other adults working with the child), groups, environmental factors, and programmatic needs (see Table 3). According to Brannen et al. (2000), effective implementation includes consultation, collaboration, and teamwork. Throughout the intervention process, the occupational therapy practitioner works collaboratively with the client and other team members such as family members, instructional personnel, school administrators, and private practitioners who may serve the student. Interventions are respectful of the customs, beliefs, activity patterns, behavior standards, and expectations accepted by the society of which the client is a member. Along with the provision of strategies and techniques that assist the child with making progress, education and training of other team members also is an important service that occupational therapy practitioners provide. Interventions are provided in natural school environments (e.g., classroom, playground, cafeteria), occurring in the time and place that is most beneficial for the student. As noted in Hanft and Shepherd (2008), the primary setting for occupational therapy services incorporates daily routine and contexts important to the student.

**Table 3. Occupational Therapy Services and Supports for Students 3–21 Years Under IDEA Part B**

<b>IDEA Part B Performance Areas</b>	<b>Occupational Therapy Services and Supports</b>
Academic	Provide consultation with curriculum planners to support academic achievement by identifying needed curriculum accommodations and modifications for standardized testing; suggest adaptations to curriculum materials, methods, processes, and production; identify and provide needed transition supports and services targeting post-secondary goals
Developmental	Foster development of pre-academic skills, including prewriting and pre-scissor skills; toileting skills; eating and drinking skills; dressing and grooming tasks; communication skills; management of sensory needs; social skills
Functional	Facilitate use and management of school-related materials, daily routines/schedule, written school work, task/activity completion, transitions among activities and persons, adherence to rules, self-regulation, interactions with peers and adults, participation in leisure and recreational occupations at home, school, and the community; use of adaptive and assistive technology to support participation and performance  Assist school in locating driver education training for students with disabilities. Collaborate with family and school staff in the development and implementation of transition programs, including preschool and high school transition. Collaborate with school personnel

	in the design and implementation of positive mental health programs and positive behavioral support systems
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Outcomes are measured by student achievement of the IEP goals and other educational objectives such as curriculum expectations. Outcome measurement for instruction may include participation on national, state, and/or district-wide assessments that are supported by services provided by the occupational therapy practitioner. Outcome measurement for occupations such as self-care, play, leisure, social participation, and work transition that typically are addressed by occupational therapy practitioners in the school setting is accomplished by monitoring progress on IEP goals focused on these areas. Data collected on identified outcomes is reviewed by the IEP team to assist with determining present levels of academic achievement and functional performance and is reported during the required annual review.

*Section 504/Americans with Disabilities Act*

Section 504 of the Rehabilitation Act prohibits discrimination on the basis of disability for any program receiving federal funds, including schools, early intervention, and Head Start programs. The Americans with Disabilities Act also prohibit discrimination on the basis of disability in education, employment, transportation, health care, and a host of other services and activities of state and local governments, including child care. Students with disabilities who are not eligible for services under IDEA may be eligible under Section 504 or the ADA if the disability is such that it significantly limits “one or more major life activities.” Examples include students who have HIV/AIDS, asthma, arthritis, attention deficit disorder/attention deficit hyperactivity disorder, traumatic brain disorder, conduct disorder, or depression.

Occupational therapists may be asked to help local school district teams determine student eligibility under Section 504 and to assist in the identification of services and development of the 504 plan. If the 504 committee determines that an educational need for occupational therapy exists, services may be provided directly to a child or as a necessary accommodation. While no additional federal funds are available for services under Section 504 or the ADA, compliance with the requirements are mandatory for early childhood and school settings.

*Response to Intervention and Early Intervening Services*

Two provisions in the 2004 reauthorization of IDEA provide additional opportunities for occupational therapy practitioners to contribute to the success of general education students who are struggling with learning or behavior. The first of these provisions, Early Intervening Services (EIS), provides supports for students in kindergarten through 12<sup>th</sup> grade who are struggling with learning or behavior. School districts can use a portion of their IDEA funds to provide professional development for teachers and other staff and to provide direct services such as educational and behavioral evaluations, behavioral interventions, small group instruction, and instruction in the use of adaptive and instructional software for students who “need additional academic and behavioral supports to succeed in the general education environment” (see §613(f)(1)).

The second provision, Response to Intervention (RtI), is a systematic process that closely monitors how students respond to different types of services and instruction. In the RtI process,

increasingly intense levels of support are provided. Decisions about which supports to provide and at what level of intensity are made through progress monitoring and data analysis. At each step of the process, monitoring and record keeping provide critical information about the student's ongoing instruction and intervention needs.

Both EIS and RtI are preventative, proactive strategies aimed at minimizing the occurrence of behavior and learning problems as early as possible, thereby reducing the need for more intensive services later. When these approaches are used, occupational therapy practitioners implement strategies that can be used throughout a school. For example, suggestions might include the use of wide-lined paper or a pencil grip to support improvements in handwriting, modification of the classroom environment to increase accessibility, use of elastic-waist pants for a child unable to fasten clothing after toileting, strategies to deal with a child who hits others on the playground when he or she becomes frustrated, or general strategies for breaking down steps for jumping rope so that a child struggling with this skill can be successful in physical education. In addition, occupational therapy practitioners may collaborate with other professionals to design school-wide positive mental health programs, positive behavioral support services, and anti-bullying campaigns.

The occupational therapy role in EIS and RtI will vary from state to state and from district to district depending on how these provisions are implemented. Because both initiatives are targeted toward general education, school-based practitioners may need to educate student support teams on how occupational therapy helps meet student's learning and behavioral needs in those environments. In addition, practitioners should participate in state and district professional development activities related to EIS and RtI and become full participants on the local teams considering interventions and supports students need to succeed in school (Clark, 2008; Clark & Polichino, 2008; Jackson, 2007).

## **OT and OTA Partnerships**

Occupational therapists and occupational therapy assistants work together in early childhood and school settings to deliver needed services. Occupational therapists are responsible for formal evaluation and also are accountable for the safety and effectiveness of the service delivery process, including intervention planning, implementation, outcome review, and dismissal/discharge. The occupational therapy assistant implements the intervention plan under the supervision of and in partnership with the therapist. State occupational therapy regulatory agencies determine supervision frequency, methods, and documentation.

## **Supervision of Other Personnel**

Many early intervention programs, schools, or community agencies employ paraprofessionals to assist in the classroom or to provide direct support to some students. The occupational therapist may utilize these individuals, as allowed by state law and regulation, to carry out selected aspects of a service. Paraprofessionals must be properly trained and carefully supervised at all times to assist with the provision of selected activities or programming that will enhance the student's

ability to achieve his or her IEP goals or IFSP outcomes. Paraprofessionals do not provide skilled occupational therapy, nor are they substitutes for the occupational therapist. Paraprofessionals perform only those tasks that can be safely performed within the child's routine and do not require the expertise of an occupational therapist or occupational therapy assistant.

The tasks delegated to a paraprofessional should be documented. A plan to train and supervise the paraprofessional must be developed by the occupational therapist. An occupational therapy assistant may train and supervise a paraprofessional in specifically delegated tasks; however, the occupational therapist is ultimately responsible for monitoring programs carried out by paraprofessionals and occupational therapy assistants.

## Conclusion

Occupational therapists and occupational therapy assistants provide services to children and youth, families, caregivers, and educational staff within a variety of programs and settings. The ultimate outcome of occupational therapy services in early childhood and school programs is to enable the child to participate in ADLs, education, work, play, leisure, and social interactions.

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