BARNES, SUZANNE BETHEA. The History of The Greensboro Cerebral Palsy and Orthopedic School. (1970) Directed by: Dr. Lawrence Vanella. pp. 92

Cerebral palsy is a condition characterized by motor disorders resulting from non-progressive abnormalities of the brain. The location of the lesion determines the specific symptoms of this condition. Etiological factors may be pre-natal, natal, or postnatal. Classification of cerebral palsy may be based on physiological grouping, neuromuscular characteristics, topography, or therapeutic needs. Various disorders are found in conjunction with cerebral palsy.

The Greensboro Cerebral Palsy and Orthopedic School, founded in January 1950, is presently in its twentieth year of operation. Founded by parents of local cerebral palsied children, this institution has undergone steady expansion and extension of service. The School was begun in temporary housing with twenty patients and a staff of three volunteers and two paid part-time therapists. Today the professional staff of eighteen serves one hundred seven patients. Operating expenses have risen from $59.75 per month in 1950 to estimated expenditures of $146,000 for 1970. Tuition and therapy charges are supplemented by aid received from the Greensboro City School System and the United Fund.

The original curriculum included preschool training, academic training, and limited physical and speech therapy. Today there are two preschool classes, eight academic classes, and a full program of physical, speech, and occupational therapy. Extensive medical services

and local welfare programs provide each child with every possible aid. The Greensboro Cerebral Palsy and Orthopedic School contributes a needed service to the Greensboro area.

THE HISTORY OF THE GREENSBORO CEREBRAL PALSY AND ORTHOPEDIC SCHOOL GREENSBORO, NORTH CAROLINA

by

Suzanne Bethea Barnes

A Thesis Submitted to
the Faculty of the Graduate School at
The University of North Carolina at Greensboro
in Partial Fulfillment
of the Requirements for the Degree
Master of Arts

Greensboro
April, 1970

Approved by

Thesis Adviser

APPROVAL SHEET

This thesis has been approved by the following committee of the Faculty of the Graduate School at The University of North Carolina at Greensboro.

Thesis Adviser _____

Oral Examination Committee Members _____

_____

_____

_____

April 10, 1970
Date of Examination

ACKNOWLEDGEMENTS

I would like to express appreciation to Dr. Lawrence Vanella for his overall assistance and supervision and to Mrs. A. M. Inman and Mrs. Robert Little of the Greensboro Cerebral Palsy and Orthopedic School for their assistance and encouragement. Special gratitude is due to my daughters, Virginia and Elizabeth, for their patience and understanding. These persons, as well as many others, have aided greatly in the preparation of this manuscript.

TABLE OF CONTENTS

IV. CONCLUSIONS

Chapter I

CEREBRAL PALSY

Introduction

Cerebral palsy is one of our society's most complicated and most prevalent disorders. The number of cerebral palsied persons in the United States is approximately five hundred and fifty thousand. The prevalence rate is about three per thousand population. A national agency estimates that every fifty-three minutes a new cerebral palsied child is born.[1] In order to present even a cursory examination of this subject several aspects of the problem should be covered. Topics to be discussed in this presentation will be the central nervous system, causes of cerebral palsy, classification systems, and disorders related to cerebral palsy. A definition of cerebral palsy will be offered and terms used throughout the study, hopefully, will be meaningful to many persons because of the modern medical-psychological-social approach which is being used in treating cerebral palsy.

---

[1]Eugene T. McDonald and Burton Chance, Cerebral Palsy (Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1964), p. 1.

Brief Historical Background of Cerebral Palsy

Cerebral palsy is not a new discovery. Ancient Egyptian sculptures depicted cripples resembling cerebral palsied persons. The Bible makes many references to cripples. Acts 3:2 describes a beggar as "lame from his mother's womb." Artists from the time of the Renaissance depicted cerebral palsy victims. The earliest medical description which can be found appeared in a pediatric textbook dating back to 1497 (Metlinger). The earliest pathologic studies of atrophied brains were reported in 1827 (Cazauvieth).[2]

John Little, an English surgeon, was the first person to isolate cerebral palsy.[3] He recognized the relationship of obstetric difficulties to abnormal mental conditions of children, especially those with spastic-rigidity conditions. Little delivered a series of lectures at the Royal Orthopedic Hospital in London in 1853 based on his findings. The birth palsies of cerebral origin became commonly referred to as "Little's disease." However, almost a century elapsed before cerebral palsy was further defined and investigated.

The term "cerebral palsy" was first used by Dr. Winthrop M. Phelps, an American physician.[4] He used the word "cerebral" to refer to the brain

---

[2]Eric Denhoff and Isabel Pick Robinault, Cerebral Palsy and Related Disorders (New York: McGraw-Hill Book Company, Inc., 1960). p. 4.

[3]Ibid., p. 4.

[4]Ibid., p. 4.

and the word "palsy" to describe the lack of motor control. Interest in cerebral palsy was further sparked by World War II and increased knowledge of brain damage in general. Until this time cerebral palsy had been considered a hopeless problem, for any brain damage was thought to be irreversible and intellectual potential to be fixed. World War II marked the beginning of the modern approach to cerebral palsy.

Cerebral Palsy Explained Medically

Cerebral palsy is a condition rather than a disease. The term is used to cover individuals who are handicapped by motor disorders which are due to nonprogressive abnormalities of the brain. Motor disorder is the primary difficulty which distinguishes the cerebral palsied person. Thus no illness or infective qualities are present. In fact, a person is not diagnosed as cerebral palsied until all evidence of any active disease has subsided.

Denhoff defines cerebral palsy as one component of a broader brain damage syndrome comprised of neuromotor dysfunction, psychological dysfunction, convulsions, and behavior disorders of organic origin.[5] "Thus the definition of cerebral palsy cannot be limited to a concept of trauma, but is better expressed as a deviation in total function which results from adverse influences operating before or at the time of birth or

---

[5]William M. Cruickshank, et al., Perception and Cerebral Palsy (Syracuse, New York: Syracuse University Press, 1965), p. 5.

in the early formative years during the development of the central nervous system."[6] Therefore, the writer intends to consider all aspects of cerebral dysfunction in discussing cerebral palsy rather than describing motor dysfunction only.

Some background knowledge of the central nervous system is needed in order to fully understand cerebral dysfunction. The nervous system is made up of the brain, spinal cord, and peripheral nerves. The transformation of the neural tube, which is derived from ectoderm, into three simple divisions is the first step in the development of the brain.[7] This takes place in the first few weeks of fetal life. The following outline shows how the several parts of the mature brain evolve from the embryonic neural tube.

I. Forebrain
   A. Telecephalon
      1. Cortex
      2. Corpus Striatum
   B. Diencephalon
      1. Thalamus
      2. Hypothalamus

Neural Tube:[8]

---

[6]Denhoff, Cerebral Palsy and Related Disorders, p. 2.

[7]William M. Cruickshank and George M. Raus, Cerebral Palsy: Its Individual and Community Problems (Syracuse, New York: Syracuse University Press, 1955), p. 28.

[8]McDonald, Cerebral Palsy, p. 13.

II. Midbrain
  A. Mesencephalon
    1. Colliculi
    2. Peduncles

III. Hindbrain
  A. Metencephalon
    1. Pons
    2. Cerebellum
  B. Myelencephalon
    1. Medulla

The motor system is comprised of the motor cortex, the pyramidal system with its associated pathways to the cerebellum and hypothalamus, the cerebellum, the extrapyramidal system, the reticular formation, the vestibular nuclei, and the spinal cord.[9]

The pyramidal system refers to the fiber tracts which descend without interruption from cell bodies in the cortex to the level of the spinal cord. Here they synapse with the peripheral nerve which is the common path of the cortex where the fiber originated. In the medulla eighty per cent of the fibers cross to the opposite side before descending. Thus the right side of the brain controls the left side of the body and vice versa.

The extrapyramidal system is made up of all fibers not in the pyramidal tracts, but they do send impulses from the brain to the spinal cord. "There are many connections with nuclei in the thalamus, basal ganglia, midbrain, cerebellum, medulla, and the reticular

---

[9]Cruickshank, Cerebral Palsy, p. 29.

formation."[10]

The lowest level of motor integration takes place in the spinal cord. Three reflexes associated with the movements of the limbs are mediated at this level. They are the flexor withdrawal reflex, the extensor thrust reflex, and the cross extensor reflex.

The pontine level is the brain stem level. Here afferents from receptors in the inner ear and muscles of the neck enter the nervous system.[11] Head positions give stimuli which produce postural reaction.

At the midbrain level tactile stimuli modify motor responses. Several righting reflexes are integrated here. In normal persons these reflexes come under cortical control.

The nervous system has access to stimuli from all the body's receptors on the cortical level. Here the nervous system should be able to control its motor activities and modify them in response to environmental conditions.

The symptoms of cerebral palsy depend a great deal upon where in the brain the lesion is located. Spasticity results primarily from pyramidal lesions. Athetosis, tremor, rigidity, and atonia result from damage to the extrapyramidal system. Cerebellar lesions cause ataxia. These symptoms will be discussed further as cerebral palsy is classified

---

[10]McDonald, Cerebral Palsy, p. 14.

[11]Ibid., p. 18.

symptomatically.

Etiological Factors of Cerebral Palsy

There are numerous causes of cerebral palsy. According to the etiologic classification of cerebral palsy used by the American Academy for Cerebral Palsy, the causes are divided into three groups: prenatal, natal (or paranatal), and postnatal. These account, respectively, for thirty, sixty, and ten per cent of the cases. There are also certain specific etiologic factors which correlate with certain neurologic sequelae.[12]

Prenatal factors are those occurring from the time of conception until the onset of labor. These factors are further divided into hereditary and acquired. Hereditary factors are genetically transmitted and may involve racial or familial predilections and, often sex-linked symptoms. Type of involvement present are hereditary athetosis, familial tremor, and familial spastic paraplegia. Acquired factors are prenatal infection (chiefly rubella), prenatal anoxia, prenatal cerebral hemorrhage, kernicterus due to Rh factor, metabolic disturbances (diabetes), gonadal irradiation, and bleeding in the first trimester of pregnancy. Spasticity or athetosis most generally occur and, unfor-

---

[12]William A. Reilly and James G. Hughes, eds., Pediatric Endocrinology-Brain Damage in Children (Philadelphia: W. B. Saunders Company, 1957), p. 1003.

tunately, mental deficiency is seen in seventy per cent of these cases.

Natal factors are those acting from the onset of labor until viability of the fetus. Anoxia is the most common natal factor. Anoxia may be due to mechanical respiratory obstruction, atelectasis, narcotism, placenta praevia or abruptio, maternal anoxia or hypertension, or breach deliveries with a delay of aftercoming head. Athetosis is the most common result of anoxia, with some spastic paraplegia also found.

The second category of natal factors are those involving trauma and hemorrhage. This may be the result of disproportions, malposition, injurious forceps application, holding back the head, pituitary-extract induction of labor, or sudden pressure changes (precipitate or Cesarean delivery). Spastic quadraplegia, spastic hemiplegia, and rigidity are often associated with these occurrences.

There are also constitutional factors. These result from prematurity, congenital syphilis, anemia, and hemorrhagic disease of the newborn. Athetosis is frequently the result. All forms of cerebral palsy show increased frequency of prematurity, placenta praevia, high-forceps delivery, and breach extractions. The rate of incidence is also higher where multiple births are involved.[13]

Postnatal factors are those accidents occurring after birth. These

---

[13]Bronson Crothers and Richmond S. Paine, The Natural History of Cerebral Palsy (Cambridge, Massachusetts: Harvard University Press, 1959), p. 66.

would include trauma, infection (usually childhood diseases such as meningitis and encephalitis), toxic causes (lead, arsenic), vascular accidents (more common in adults--aneurysms, embolism, thrombosis), anoxia, and neoplastic or late-development defects (tumors, cysts). Prognosis is usually good for postnatally acquired spasticity.[14]

Those factors which affect the development of the central nervous system before differentiation takes place (first two trimesters of pregnancy) give a poorer outlook due to the fact that damage has been superimposed on an underdeveloped cortex. Factors which influence the nervous system before the major spurt of growth (from the last part of pregnancy through the third year) carry a better outlook. Damage occurring in later infancy and childhood thus has the best prognosis.[15]

Tests to Assess Brain Damage

Special tests have been designed to assess the brain damage involved. The electroencephalogram (EEG) produces information concerning the electrical activity of the brain. A record of electrical voltages or brain waves is picked up by tiny electrodes attached to different regions of the scalp. Normal brain waves are rhythmic. Abnormal waves are usually spiked and uneven. The EEG is helpful

---

[14]Denhoff, Cerebral Palsy and Related Disorders, p. 10.

[15]Ibid., p. 21.

in determining the location of the pathological condition by indicating the regions where dysrhythmia occurs and the extent of this dysrhythmia.[16]

The pneumoencephlagram is a procedure in which a small amount of cerebrospinal fluid is removed and replaced with air, hypodermically. The brain has four cavities, or ventricles, which communicate with each other. The air moves through these spaces and provides enough contrast to the brain tissue itself for x-rays to be meaningful. The mortality rate and the chance of further damage to the brain are high in this test. It is usually done to rule out abnormalities, tumors, and subdural hemotoma rather than as a routine procedure.

Cerebrospinal punctures (spinal taps) are done to detect hemorrhage, infection, or blocks. Simple skull x-rays and general x-rays are often done to detect developmental defects or fractures as well as to determine bone age.[17] General laboratory tests are also run. Obviously prognosis and treatment are dependent upon early and precise diagnosis.

Classification of Cerebral Palsy

Cerebral palsy can be classified in different ways, depending upon the viewpoint. The first method of classification which will be con-

---

[16]McDonald, Cerebral Palsy, p. 33.

[17]Reilly, Pediatric Endocrinology, p. 33.

sidered is one which divides cases into two major physiological groups. In the first group are those cases in which structural change involves the pyramidal section of the brain. This accounts for most of the types of spasticity. In the other group are those cases in which the extrapyramidal system is involved. This involvement accounts for most of the nonspastic and mixed types, with athetosis being the most common disorder of movement.[18] (The terms spastic and athetoid will be further defined later.) The writer feels that this method of classification is too general and too overlapping to be of practical assistance.

Classification may be based on neuromuscular characteristics. This is a commonly used system and is made up of six groups. The first group, spasticity, is characterized by an increase in the stretch reflex. An increase in tone is found in the spastic muscles accompanied by a weakness in the muscles in opposition to the spastic muscles. Hyperactive stretch reflexes are particularly noticeable in the antigravity muscles.[19] Flexion deformities are common, particularly in the large joints. Muscle contraction time is slow. Overall motor activity in the spastic is poorly coordinated. Spasticity accounts for about sixty-five per cent of all cerebral palsy cases and is associated with upper motor neuron lesions.

---

[18]Crothers, Natural History, p. 45.

[19]McDonald, Cerebral Palsy, p. 35.

Athetosis refers to involuntary movements which occur with voluntary efforts and interferes with normal muscular functions. The movements may be tremor or rotary and may occur with tension. Tremor motions consist of flexion and extension in hinged joints. Rotary motions are the result of involuntary contractions of the muscles around the ball-and-socket joints.[20] Motions and tensions increase in times of stress. Characteristic deformities rarely develop. Athetosis, accounting for some thirty per cent of all cerebral palsy, is attributed to lesions in the extrapyramidal tract or in the basal ganglia.

Ataxia is primarily incoordination due to disturbance of kinesthetic or balance sense, or both. Muscles are normal, although they may be weak. Reflexes are normal. The sense of position in space is disturbed. Ataxia is usually the result of cerebellar lesions.

Tremor refers to fine, repetitive, rhythmic, involuntary contractions of flexor and extensor muscles. Muscle tone and reflexes are normal. Tremors may be intentional or non-intentional. Intentional tremor is not present during rest. Non-intentional tremor is present at all times. Deformities are not found in tremor cerebral palsy.

Rigidity refers to resistance to flexion and extension movements. It is the result of simultaneous contraction of both agonist and antagonist muscle groups. Rigidity may be constant or intermittent. During the

---

[20] Ibid., p. 35.

intermittent periods the muscles are weak and reflexes are diminished or absent.[21] This is a generalized disturbance of neuromuscular function which affects all extremities. Deformities are quite common with rigidity.

Atonia refers to lack of muscle tone and failure of the muscles to respond to volitional stimulation.[22] Weak stretch reflexes are found. Atonia is often used more as a descriptive term than as a distinct and separate category.

It should be noted here that many cerebral palsied persons exhibit mixed neuromuscular characteristics. In these instances, the case is classified according to the predominant characteristic.

Classification may be made on the basis of topographical distribution of involvement. This means classification according to the number and location of the limbs involved. Hemiplegia refers to one side of the body being affected. Paraplegia refers to involvement of both legs. Quadraplegia means involvement of all four extremities. In diplegia all four extremities are affected, but mostly the legs. Triplegia refers to involvement of three extremities--usually both legs and one arm. Monoplegia, which is extremely rate, means that only one limb is affected. Double hemiplegia means involvement of all four extremities, but mostly the arms.

---

[21] Ibid, p. 37.

[22] Denhoff, Cerebral Palsy and Related Disorders, p. 31.

The most common categories are hemiplegia, paraplegia, and quadraplegia. Hemiplegics are most often spastic, but other athethosis or rigidity can occur. Paraplegics are most likely to be spastic. Quadraplegics may have any of the neuromuscular characteristics.

Therepeutic needs may be used as a basis for classifying cerebral palsy. This would correlate with a classification system based on degree of severity. Class A patients would not need treatment and, thus, would include cases with no practical limitation of activity. Class B patients are those with slight to moderate limitations who need minimal bracing and minimal therapy. In Class C are found those who need bracing and apparatus and the services of a cerebral palsy treatment team. Those patients who are unable to carry on any useful physical activity would fall into Class D. They are limited to such a degree that long-term institutionalization and treatment are required.

Functional classification of neurologically handicapped children must be included due to the fact that many of the cerebral palsied have multiple afflictions. Neuromotor dysfunction refers to fine or gross neuromuscular incoordination. Cerebral palsy falls into this classification. Intellectual dysfunction is functional or organic mental retardation. Neurosensory dysfunction includes visual and auditory impairments of neurologic origin. Under behavioral dysfunction are found hyperkinetic behavior disorders and childhood schizophrenia. Percep-

tual dysfunction refers to visuomotor, tactile, or auditory distortions contributing to learning difficulties and the establishment of relationships. It should be noted that injury, mal-development, delayed maturation of the brain, or intense emotional stress can cause any or a combination of these various disturbances.[23]

Disorders Related to Cerebral Palsy

Cerebral palsy has many related disorders. The presence and severity of any additional disorders must be fully understood by anyone who works with the cerebral palsied. Approximately forty per cent of cerebral palsy patients have seizures.[24] These seizures vary according to frequency and intensity. The highest incidence seems to appear in cases of postnatally acquired hemiplegia in which seventy-five per cent of the patients suffer from seizures. The incidence runs about fifty per cent in spastics and eighteen per cent in athetoids.

There are three types of seizures most commonly seen. Petit mal seizures are characterized by a loss of attention which usually lasts only momentarily. This is often difficult to detect. Jacksonian seizures are characterized by jerking which begins in one extremity and spreads over the rest of the body. Grand mal seizures, or major psychomotor

---

[23] Ibid., p. 4.

[24] Reilly, Pediatric Endocrinology, p. 1007.

disorder, are characterized by loss of consciousness, gross jerking over the entire body, and foaming at the mouth. This is normally followed by a period of deep sleep, which in turn may be followed by confusion or temporary amnesia. Seizures usually begin at about six months of age and may cease spontaneously after a number of years. Pharmocological treatment is the most effective treatment of seizure problems.

Sources vary in their estimates of intellectual impairment among the cerebral palsied. However, the writer feels that most authorities would agree that there is intellectual impairment in at least fifty per cent of cerebral palsy cases. From a behavioral point of view, more than seventy per cent of cases conduct themselves as if they were mentally retarded.[25] Those persons having the highest incidence of retardation are those having prenatally acquired cerebral palsy. The intellectual potentialities of cerebral palsied patients can be assessed more easily now through new psychological tests for physically handicapped children.

Emotional problems are prevalent among cerebral palsied persons. McDonald bases the reason for this prevalence on the delayed maturation of any physically handicapped child. This child does not experience the normal opportunities for emotional growth. He has less opportunity to

---

[25]Robert M. Allen and Thomas W. Jefferson, Psychological Evaluation of the Cerebral Palsied Person (Springfield, Illinois: Charles C. Thomas, 1962), p. 7.

develop his interests. He often fails to develop the responsibility for making decisions. Unfavorable parental attitudes are another factor. The cerebral palsied child, as any child, needs an environment which is both stimulating and accepting. The patient's self-concept regarding the presence of his disabilities appears to be basic in regard to his potential for satisfactory emotional adjustment.

Hyperkinetic behavior can be a complicating factor. This is characterized by constant over-activity, short attention span with poor powers of concentration, impulsiveness, explosiveness, and irritability. In other words, the hyperkinetic behavior syndrome couples over-active movements with gross behavioral variability. This syndrome accounts for many of the patients who conduct themselves as if they were mentally retarded.

Speech and hearing problems are very frequent. While seventy per cent of cerebral palsy patients have speech impediments, there is no speech which can be termed "cerebral palsied speech." The group having the highest incidence of speech defects is the athetoids. Here the rate, melody, and stress are impaired. Speech is jerky, irregular, and explosive, often coupled with breathing abnormalities. The speech of the spastic is slow, labored, and effortful. The ataxic have overall flaccidity characterized by monotonous, sluggish speech which can be practically inaudible. The most difficult speech problems are encountered

when paralysis of the speech mechanism is involved.

The athetoid group also has the highest incidence of hearing problems. They often have a high frequency hearing loss which can easily be overlooked. There are different types of hearing loss. Perceptive loss is due to nerve damage. Conductive loss is due to some obstruction in the passage of sound to the inner ear. This is never complete and is often surgically repairable. Central loss is due to the disturbance of the pathways from the brain stem to and including the cerebral cortex. Hysterical or convulsive deafness may be found. Until it can be proved otherwise, every cerebral palsied child should be suspected of having a hearing loss.[26]

Perceptual and conceptual disorders must not be overlooked. Perception is the process of organizing and interpreting the sensations which an individual receives from internal and external stimuli.[27] There are several types of perceptual disorders. As discussing these would require detailed definitions, the writer will merely list some of them. They include dyscalculia, agnosia, agraphia, apraxia, and alexia. These are considered to be central blocks to normal responses. Conceptual thought includes most forms of abstract thinking. It is not thought to be as relevant to children's syndromes of cerebral dysfunction

---

[26]McDonald, Cerebral Palsy, p. 47.

[27]Denhoff, Cerebral Palsy and Related Disorders, p. 85.

as is perceptual disorder.

Summary

Care for the cerebral palsied is based on its causes, its effects, and any related disorders which may be present. For this reason, the writer felt that these topics should be explored. The writer wishes to stress that cerebral palsy is a sensorimotor disorder and not a disease. Knowing the causes of cerebral palsy--prenatal, natal, and postnatal factors--help to make this condition more understandable. Classification of cases can be achieved in different manners. The most meaningful system is usually determined by the reasons for which one wishes to classify patients. For example, a physical therapist would be inclined to use a system based on topography while a neurosurgeon may prefer one based on the factors responsible for the condition. Anyone working with the cerebral palsied needs to be aware of the related disorders which are so often present. As treatment of cerebral palsy is a team effort by various medical and para-medical personnel, there are many persons who must be familiar with the precise definition of, causes of, and various methods of classification of cerebral palsy.

Chapter II

THE ESTABLISHMENT AND HISTORY OF THE GREENSBORO CEREBRAL PALSY AND ORTHOPEDIC SCHOOL[28]

Factors Leading to Establishment of the School

The existence of the Cerebral Palsy and Orthopedic School in Greensboro, North Carolina, resulted largely from the desire of local parents of cerebral palsied children to provide specialized care for their children and other cerebral palsied children. In January 1949, Mrs. Charles Bennett decided to form a parents group in order to ascertain what could be done to help these children. She contacted the Greensboro Daily News Company with the idea of placing an ad in the personals column of the paper. She was informed that this type of item belonged in the news section and could only be placed by an organization. Thus arose the necessity for forming an organization.

Mrs. Bennett contacted Mrs. R. B. Deal and three other parents.

---

[28]Information pertinent to the establishment of the Greensboro Cerebral Palsy and Orthopedic School and appearing herein was gleaned from the minutes of the annual meetings of the Greensboro Cerebral Palsy Association and the minutes of the monthly meetings of the Board of Directors of the Greensboro Cerebral Palsy and Orthopedic School. These minutes covered the period from late 1949 (no month given) through March 1970. The minutes are on file at the Greensboro Cerebral Palsy and Orthopedic School. Additional information was obtained from We Will Win by Minnie Bennett (private publication).

Within six weeks ten families had been found, and a meeting was arranged for March 1949. At this time the Greensboro Cerebral Palsy Association was formed with Mrs. Bennett as president. Mr. James Fogarty, Executive Secretary of the Council of Social Agencies, gave help and advice to the group. The North Carolina League for Crippled Children asked the group to head their Easter Campaign for Guilford County. Members of the Junior League of Greensboro and the Greensboro Junior Woman's Club maintained booths in the downtown area for selling stamps. The Easter Campaign was not considered successful due to the small amount of money raised; however, the public was made more aware of the existing problem. The Association, with the help of Dr. E. R. Troxler, organized a radio program to further publicize its needs.

In June 1949, Mrs. Charlotte White, a Greensboro native who was a speech therapist, returned to Greensboro. The parents group contacted Mrs. White and found that her services were available. The group decided to open a temporary clinic. The Greensboro City School Board allowed them to use a room at Central Junior High School for speech therapy classes. These classes were held three days per week. Mrs. Deal and Mrs. A. D. O'Bryan were responsible for obtaining members of the Junior League to transport the children.

In October, Mrs. White and Mrs. Bennett attended the organizational meeting of the United Cerebral Palsy Association in New York City. At this convention they gained invaluable knowledge and were

able to form more concrete ideas regarding a local facility. As a result of their reports the parents group was determined to open a clinic immediately.

Money and a building to use were the first necessary items. Mrs. Willard Cardwell, a well-known local soprano, sponsored by the Greensboro Pilot Club (a business women's organization), gave a concert which netted $1,000. Mr. Oscar Burnett offered the former dental clinic barracks of an old Army post located in what is referred to locally as the O.R.D. section. (This section of the city is so called because it was the site of the Overseas Replacement Depot in use during World War II.) The building contained 2,500 square feet. Mr. Burnett and Mr. Fred Williams contributed toward the restoration of said facility. Mrs. P. A. Hepler, a parent, was made chairman of equipment. Through the help of local firemen, the city was canvassed for usable articles upon which the firemen made necessary repairs.

The building was painted by Mr. R. W. Griffin, a father who was a professional painter. Mr. Wade Cornatzer, another father and a local merchant, was able to make many wholesale purchases aided by a contribution from the Greensboro Council of Jewish Women. The Greensboro Cosmotologist's Club, the Greensboro Exchange Club, and the Exchangettes (wives) also contributed time and equipment. Others who were especially helpful through volunteering time and effort included Mr. Edsel

Clapp, Mr. F. A. Sockwell, and Mr. A. D. O'Bryan.

Mrs. Bennett and Mrs. G. E. Bell planned the curriculum for the School. They made arrangements for two groups: nursery and academic training. Mrs. Bell served as Acting Director of the School and as the nursery teacher. Miss Marilyn Hill, a college student preparing to work with cerebral palsied children, was retained to teach the academic class. Mrs. Bennett agreed to assist both groups. Mrs. White's services in speech therapy were obtained for one hour each week. Mrs. McKibben Lane, a local graduate psychologist, volunteered her services for one hour per week to do psychological evaluation tests. The Junior League agreed to make the School one of its projects, helping to organize the School's Board of Directors and helping to make rules and regulations for the School.

The Opening of the School

On January 11, 1950, registration for the Cerebral Palsy Training Center was held. Applications from twenty children were received. The Center was to be in operation two afternoons weekly for two hours each. The first session was scheduled from January 12 through May 18. No policies had been established at the time of registration.

A Steering Committee consisting of five persons appointed by the parents group and five persons appointed by the Junior League was established. The committee was comprised of Mrs. Bennett, Mr. O'Bryan,

Mrs. Bell, Mrs. R. W. Griffin, and Mr. Cornatzer, parents; and Mrs. Clyde Andrew, Mrs. E. K. Atkinson, Mrs. A. M. Inman, Mrs. Edward Loewenstein, and Mrs. Jack Estes, Junior League members. The Steering Committee first met on Thursday, January 12, 1950, at the Young Men's Christian Association. Mrs. Bennett, President of the Cerebral Palsy Association, gave background information on the origin of the Center and reported on the registration of students which had occurred the previous day. The functions of the Steering Committee were to act as a nominating committee for a permanent Board of Directors for the Center and to assume the responsibility for operating the Center until such time as the Board of Directors could begin doing so. Mrs. Andrew was elected Chairman of the Steering Committee.

The following policies were adopted by the Steering Committee:

1. Only children diagnosed as cerebral palsied by a medical doctor would be accepted.
2. No child would be accepted under two years of age or over sixteen years of age.
3. Children would be accepted in order of application.
4. The Center could ask for removal of any child whom the staff felt could not be helped by attending the Center.
5. No parent would be permitted to stay at the Center with the child unless requested to do so by the staff.

6. Enrollment at the Center was limited to twenty-five, with a maximum of fifteen in the academic training group.
7. There would be no charge made to the parents.

The parents group asked local civic organizations to appoint members to an Advisory Committee from which a permanent Board of Directors would be chosen. The Steering Committee, however, did not consider this to be the best way in which to obtain a working Board. For this reason no formal meeting of the Advisory Committee was held.

The Steering Committee met again on January 26. Mrs. Andrew reported that the Guilford County Health Department was willing to provide the Cerebral Palsy Training Center with the same services provided for the City School System. On March 28, the Steering Committee met with the persons nominated for the Board of Directors of the Cerebral Palsy Training Center. The decision was made at this time that all applicants must present a signed statement from a doctor stating that the child was cerebral palsied. If the expense to the parents made this prohibitive, the Board would accept responsibility for payment.

The Steering Committee held a joint meeting with the newly formed Board of Directors on April 17. The Board was comprised of five parents and fifteen persons not directly associated with cerebral palsy. Officers of the Board were: Mr. W. H. Holderness, President; Mrs. Inman and Mrs. Deal, vice-presidents; Mrs. S. J. Stern, Secretary; and Mr.

O'Bryan, Treasurer. An addition was made to the previously established policies. Admission preference was to be given to Guilford County residents even if others had applied earlier. Training sessions were set up under Dr. Troxler, Medical Director of the Center. At this meeting, the Steering Committee was dissolved.

Thus, after a year's effort on the part of many dedicated citizens, the Greensboro Cerebral Palsy Training Center was in operation. The Center was in session two afternoons per week for two hours each day. The staff consisted of one college student-teacher, one part-time psychologist, and one part-time speech therapist, all assisted by the time and effort of parents and volunteer workers. The operating cost of the first session was estimated as being $59.75 per month.

From this point, a year-by-year summary of the Greensboro Cerebral Palsy Training Center, including 1950 through 1969, will be presented. The summary will concentrate on highlights and significant changes occurring each year.

1950

During the summer of 1950, classes were held three mornings per week beginning on June 9. Mrs. William Barse was employed as the first full-time academic teacher. Mrs. Bell continued with the nursery group, and Mrs. White continued as speech therapist. In June, the Board made a joint agreement with the Family Service Agency for the

services of a social case worker for one-half day each week to take initial applications and to help with the problems of each child's adjustment to the School when requested to do so by either the staff or the parents. This service was made available at no cost to the School. In July 1950, the Junior League agreed to finance a physical therapist for a period of two years. Miss Ruth Holland was secured for this position.

The School began operating five mornings per week in the Fall of 1950. The Greensboro Public School holiday schedule was observed. Physical therapy was now available on a full-time basis. Volunteer workers were supplied by the Junior League. Twenty-two full-time students and ten out-patients were enrolled. Dr. Troxler and Dr. Weston Cooke of Columbia, South Carolina, conducted a clinic at which time all children were examined.

1951

By January 1951, the enrollment had been reduced to eighteen full-time patients and six out-patients. On April 30, the Greensboro Cerebral Palsy Association was incorporated. Mr. Allen O'Bryan, a parent and Member of the Board of Directors, initiated the first fund raising drive. Approximately $12,000 was collected. The decision was made to request a $2 per semester book and supply fee from the parents. The operating cost for the 1950-1951 school year was estimated as $9,000.

Mrs. James L. Odell was retained in the Fall of 1951 as speech therapist. Miss Peggy Douglas, an arts and crafts teacher, was also added to the staff. Twenty-one patients were enrolled full-time along with nine out-patients. The Board decided to admit Negro children at such time as the facilities could be expanded to provide for additional applicants. The estimated operating cost for the 1951-1952 school year rose to $12,000.

1952

As the barracks being used for the School had been condemned by the Greensboro City Council and the number of applications was increasing, the need for a larger permanent facility became apparent. In September of 1952, a building fund drive was begun under the chairmanship of Mr. L. Richardson Preyer assisted by Mr. C. W. Wyrick and Mr. John R. Foster. Mrs. Sidney Stern was Publicity Chairman. A goal of $60,000 was set, of which $40,000 would go toward building expenses and $20,000 to operating expenses.

The campaign received extensive newspaper coverage and was supported by many local clubs and individuals. In an article on Monday, September 12, 1952, The Greensboro Daily News stated that the new school would be the third of its kind in the country. A plot of land located on the corner of Gatewood Avenue and Ball Street was donated by the Bessemer Improvement Company. The Greensboro Chamber of

Commerce agreed to solicit building materials and labor donations. A total of $55,000 was raised.

1953

Ground-breaking ceremonies were held on Monday, February 16, 1953, and actual construction was begun on February 22. Mr. Edward Loewenstein, who had made the architectural drawings, was general chairman of construction. Mr. Eugene Gulledge, a local contractor, was designated building superintendent. Organizations and persons lending exceptional aid include the Greensboro Chapter of DeMolay, Veterans of Foreign Wars, the Shrine Club, the State Highway Patrol Auxiliary, the American Business Club, the Exchange Club, the Kiwanis Club, the Order of Odd Fellows, the Greensboro News Company, the Parents Group of the Greensboro Palsy Association, the Junior Woman's Club, the Sternberger Hospital Auxiliary, local non-unionized bricklayers, plumbers, firemen, electrical workers, and painters. Women's groups served hot lunches to the volunteer workers on Saturdays. Local garden clubs undertook seeding and planting of the grounds. An estimated three thousand volunteers contributed their efforts to the project.

In June of 1953, Mrs. Laura Ganoung of Tucson, Arizona, a psychologist, visited the School. She tested all children and helped plan the curriculum for the new School. Operating costs for the 1952-1953 school year were estimated as having been $16,000.

Dr. J. A. Highsmith, formerly principal of Curry School, the laboratory school at the Woman's College of the University of North Carolina, and Chairman of the Psychology Department at the same institution, was secured to be the first full-time director of the School. Another first was the services of a speech therapist who was paid by the City School System. Policy changes effective in September of 1953 were: inclusion of lunch, a tuition charge of $10 per month when financially possible, regular attendance required for continued enrollment, admission of Negro children, and the raising of the lower age limit to three years of age. Out-patient fees of $2 for speech therapy and $3 for physical therapy became effective. The hours were changed to nine a.m. to one p.m. for the nursery group and nine a.m. to three p.m. for the school group with classes being held five days per week.

The Greensboro Cerebral Palsy School opened on Wednesday, September 23, 1953, with thirty-one enrollees and a full-time professional staff of six. An aide and janitor were also added to the staff. The new facility was made up of nine rooms and contained approximately 9,000 square feet. An open house for the general public was held on Sunday afternoon, November 9, 1953. The event was hosted by Fire Chief Wyrick, also a member of the Board of Directors. Many enthusiastic citizens attended. The appraised value of the new School was $125,000. Operating expenses for the first school year in the new

building (1953-1954) rose to an estimated $21,700. Many contributions such as a spring concert by the Charlotte Boys' Choir under the sponsorship of the Shrine Club which netted over $4,000, continued to make operation of the School possible during the regular school term as well as the inclusion of a half-day summer program.

1954

During the spring of 1954, Mrs. Stern had submitted an entry on behalf of the Greensboro Cerebral School to a contest being held by the Committee on Community Projects of New York City under sponsorship of the Necchi Foundation. In August, the School was notified that it would be awarded a $1,000 third place prize for being an example of outstanding community cooperation. The School also received a wall plaque for being the most outstanding North Carolina entry.

School opened in September 1954 with an enrollment of twenty-one full-time patients and four out-patients. Mrs. Homer Coltrane became the new Executive-Director (sic). The same professional staff was retained with the same services offered plus psychological service. A tuition fee of $120 per year was charged with the Executive-Director authorized to make adjustments in hardship cases. Emphasis at this time was on organization, refinement, and expansion of services already offered.

1955

In the spring of 1955, the first annual fund-raising drive was initiated under the direction of Mr. E. C. Blaylock and netted approximately $23,000. The Board requested the Guilford County Health Department to extend to the School the dental services supplied to children attending public school. The request was denied on the grounds that the School was a private facility. However, the Guilford County Dental Association agreed to volunteer needed services. Parental counseling, home instruction programs, and increased out-patient service were stressed throughout the year. Expenses incurred during the 1954-1955 school term totaled $26,000.

During the first five years of operation the Greensboro Cerebral Palsy School received ninety-one applications; seventy-eight for full-time service and thirteen for physical therapy only. Forty-eight per cent of these children were between one and five years of age at the time of application. Over fifty per cent of the children served were found to be mentally retarded.

In October Mrs. Coltrane resigned as Executive-Director. Mrs. A. M. Inman, an active Board member, was persuaded to accept the position of part-time Acting Director. By December the impossibility of such an arrangement became apparent, and Mrs. Inman was made full-time Executive-Director. She has remained in that position for the

past fifteen years.

1956

During the 1955-1956 school year, twenty-two full-time patients and seven out-patients were enrolled. An adult arts and crafts program meeting one afternoon per week was initiated in April. This program was limited to cerebral palsied persons over sixteen years of age. Pediatric examinations were conducted by volunteer pediatricians. Operating costs for the school year were $25,500.

In August of 1956, the Greensboro Cerebral Palsy School became an agency of the United Fund. In order to furnish necessary financial reports, the fiscal year was adjusted to begin on January 1 and end on December 31 each year. (All statistical information from this point will be given on a calendar year basis.) At this time the Junior League terminated financial support although volunteer services were still rendered. Expenses for year 1956 were $32,200.

1957

Thirty-two full-time patients, seven out-patients, and seven adults were being served by the School in January of 1957. One classroom teacher, one physical therapist, and two aides had been added to the staff. Thus enrollment had increased to forty-six, and the staff had increased to eleven. Fees for out-patient services became $3 per

appointment, with the monthly total not exceeding $10. The summer program was made full-time so that the School now operated five days per week for eleven months. The Board of Directors began investigating the possibility of obtaining State aid. A By-Law change was made stating that no member of the Board of Directors could serve more than two successive three-year terms. Operating costs for the year totaled $39,200.

1958

By January 1958, an additional speech therapist had been added to the staff, and the psychological testing program had been expanded. The enrollment of fifty consisted of thirty-six full-time patients, seven out-patients, and seven adults. The Junior League renewed financial support to the School. The Board was able to secure State aid under the legislative provision for trainable retarded children. A few children from the School began to attend a new special class for orthopedically handicapped children being organized at Braxton Craven Elementary School under sponsorship of the Greensboro City School System. This arrangement was later deemed inadvisable due to excessive fatiguing of the children. The plan had necessitated the participating children having to divide their day between the two schools, thus having all therapy concentrated at one time and all academic training concentrated at another. 1958 operating costs were $46,600.

1959

The first occupational therapist and an additional classroom teacher were added to the staff in 1959. Facility improvements included the completion of an outdoor shelter by the Kiwanis Club. Enrollment rose to thirty-eight full-time patients, eleven out-patients, and seven adults. The By-Laws of the Cerebral Palsy Association were amended so that any contributor, whatsoever, to the Association would be a member for that calendar year, as is any parent of a cerebral palsied child who is a Greensboro resident. Expenses for operating the School in 1959 were $56,200.

1960

As of January 1960, a total of sixty-five patients were being served by the Greensboro Cerebral Palsy School: forty-five full-time patients, twelve out-patients, and eight adults. Regular pediatric and orthopedic clinics were now being held at the School. The School had varying arrangements with local colleges for field work and observation by students in certain fields. Affiliation was made in March with the School of Physical Therapy at the University of North Carolina at Chapel Hill to have their students observe for a full week in June. For the first time high school and college students volunteered summer assistance. As the need for additional space was becoming acute, a building committee made up of Mrs. A. T. Preyer, Mrs. Stern, and Mr. Loewenstein

was appointed. In November a request for additional aid was sent to the United Fund Capital Improvement Committee. However, no aid could be supplied at this time due to the United Fund's unsuccessful Fall campaign. Operating costs for 1960 were $57,300.

1961

Enrollment was forty-six day students, nineteen out-patients, and eight adults, making a total of seventy-three persons utilizing the School's facilities in January of 1961. The Policy Committee of the Greensboro Cerebral Palsy Association determined that approximately ninety per cent of the families of local cerebral palsied children had a problem in assuming the full tuition costs of the School. For this reason no increases in tuition or therapy fees could be made by the School despite rising costs and the need for expansion. The waiting list for school admittance now averaged fifteen to twenty. Total expenses for the year were $56,800.

1962

The enrollment in January 1962 was the same as for the previous January, with two out-patients being transferred into the day school group. During the spring, the Policy Committee compiled an updated report on the School's policies. (See Appendix p. 76.) Mrs. Inman reported to the Board in April that fifty per cent of the students being

served were under ten years of age and that fifty per cent of the out-patients were under six years of age.

The paving of Ball Street (on which the present structure faces) necessitated an extra expenditure for the School. The Board began an investigation of additional financial support on the State and Federal levels. Operating costs were $63,900 for the year.

1963

1963 began on a bright note with a report from the Financial Committee at the January Board meeting stating that Federal funds for financing an addition to the existing facility might be available under the Hill-Burton Act. On March 28, representatives of the Medical Care Commission and of the Regional Office of the Public Health Service visited the School to assess its needs. Additional funds would also be needed from the United Fund. The estimated cost of the proposed 9,000 square foot addition was $248,000.

At this time seventy cerebral palsied were being served by the School: forty-two day students, nineteen out-patients, and nine adults. Twenty-six applicants were on the waiting list. Thus the School was caring for over twice the number of students who were enrolled upon moving into the building in 1953.

Plans for the new wing were approved on June 7 by the Medical Care Commission, and $161,594 was granted for the project. $24,000 was

available in the School's Expansion Fund, $10,000 from the Junior League, $30,000 from the United Fund Capital Funds Campaign, $5,000 bequeathed by the late Mrs. Ceasar Cone, and $15,000 from the Duke Foundation. A $4,425 deficit remained. Operating expenses for 1963 were $61,800.

1964

On January 7, 1964, bids were opened for the new wing and for the necessary renovation of the existing structure. A special meeting of the Board was called the next day to consider the bids. The Board accepted the low bid--that of $226,090 submitted by J. D. Summers Construction Company. Thus the estimated construction costs plus architectural fees, supervision, and equipment rose to $280,227. Federal aid would account for 64.52% and local participation for 35.48% of this total. A $5,000 grant was received from the Z. Smith Reynolds Foundation. Construction of the new wing began toward the end of January.

In August, the Board of the Cerebral Palsy School accepted a previously made offer from the Greensboro City School System. The Cerebral Palsy School would absorb the orthopedic class which the City System had previously held at Braxton Craven, then at Brooks Elementary School. Through this arrangement, eleven children, their teacher, and an aide would be added to the School. Three additional aides, books, supplies, and other services would be furnished by the City. In return,

the Cerebral Palsy School would charge book fees, have a representative of the City System on the Board of Directors, and enter into a written agreement to that effect.

Final inspection of the new wing was held on September 3, 1964. School opening was delayed until September 8. Most necessary adjustments had been made by the end of the month, and the wing was first occupied on September 28. The School was now serving eighty-two persons: fifty-six day students, eighteen out-patients, and eight adults. Three college students were doing regular practice teaching at the School. Disbursements totaled $67,400 for the year.

1965

An Open House was held on February 7, 1965, under the direction of Mrs. David Brown. Approximately three hundred and fifty interested citizens inspected the new facility. The staff and patients were present to greet visitors. As had been the case during the construction of the original building, many organizations and individuals had volunteered services and equipment which greatly facilitated completion of the existing structure.

In the fall of 1965, eighty-two cerebral palsied and orthopedically handicapped persons were being served by the School. The full-time staff totaled twenty-four. The Guilford County Dental Society agreed to staff a regular dental clinic for the School. A public school health

nurse was assigned by the Health Department and began making regular visits. Additional library services were now available, and stress was being placed on teaching activities for daily living. Operating costs for the year were $72,900.

1966

A policy change was made in early 1966. If space became available, applicants outside of the Greater Greensboro Area might be accepted, but would be charged a monthly therapy fee based on the actual current per capita cost of such service. This charge would not include services provided by the City School System. However, no applicants were immediately accepted as eighty-three individuals were already enrolled with fourteen on the waiting list and ten having applications pending.

In April, the Board purchased property adjoining the School property on Gatewood Avenue for $18,000. The purpose of this acquisition was to protect the present facilities and to provide room for expansion. Sale of property bequeathed by the Charles W. Banner, Sr. estate made this purchase possible. In the Fall, an additional plot of land on Tucker Street was acquired for $9,000. This purchase provided access to the School from three different streets. Operating expenses for 1966 rose to $84,800.

1967

By January of 1967, sixty-eight day students, nine out-patients, and eight adults were enrolled in the Cerebral Palsy School. This number increased steadily throughout the year. The occupational therapy program was rapidly developing, and another aide was retained to work in this area. (The exact beginning of the occupational therapy is undeterminable as some aspects of occupational therapy had been previously combined with other therapies.) Increased paper work necessitated obtaining an additional secretary. Dr. Martha Sharpless, a Board member and local pediatrician, began regular pediatric clinics in May. Four such clinics were held within the first month. The library was greatly expanded by the addition of nine hundred new books to the original twelve hundred and with the acquisition of audio-visual materials.

A special study committee was appointed by the Board under the direction of the Reverend Mr. Phillip Craig to make an intense study of the School's current problems, future needs, and available avenues of financing. Upon presentation of this committee's report, the Board decided to concentrate on improving and expanding the existing program rather than moving into new areas of service. The year ended with operating expenses having totaled $94,800.

1968

The School's enrollment in January 1968 had grown to ninety:

seventy-one day students, eleven out-patients, and eight adults. Local colleges and the Guilford Technical Institute continued to use the School for observation, field work, and practice teaching. Maintenance of a full staff continued to be one of the operating problems. The back portion of a lot on Tucker Street adjoining the School's property was donated by the Kiwanis Club.

Medical services for the children were expanded with the approval of a plan whereby interns and residents at Moses H. Cone Memorial Hospital would examine the patients as part of their pediatric training. Investigation was begun into the possibility of assistance from Vocational Rehabilitation for individuals sixteen years and older. The possibility of extending service into residential care was considered by the Board, but was not deemed financially advisable at the present time.

In June, the Board approved the establishment of the position of Assistant Director of the School. Mrs. Robert Little, an active Board member and volunteer of long standing, accepted the position. She is currently serving in this capacity.

The summer program was changed to include essential academic training and therapy services in the mornings and to have day camp activities for an hour in the afternoons. The City System provided a full-time speech therapist on a year-round basis for the first time. Fortunately, most of the children were able to attend other camps while school was not in session. Expenses incurred for 1968 totaled $108,000.

1969

As of January 1969, one hundred and five persons were being served by the Cerebral Palsy School. Of these, seventy-nine were day students, eighteen out-patients, and eight adults. The School property was again increased with the purchase of adjacent property on Textile Drive for the sum of $6,000. The Kiwanis Club donated monies which enabled the building of a permanent storage building. The appearance of the School was greatly enhanced by volunteer painting by the Piedmont Chapter of the Painting and Decorating Contractors of America. The staff was increased by the assigning of a teacher to the School by the Guilford County School System.

The necessity of changing the name of the School was a topic of study during 1969. As the School had begun serving other orthopedically handicapped individuals in 1964, the Board felt a name change would extend fund-raising appeal and encourage prospective students to apply for admission. Thus the name The Greensboro Cerebral Palsy and Orthopedic School was adopted in November. The year 1969 ended with yearly operating expenses of $116,400.

Summary

During the nineteen year history of the Greensboro Cerebral Palsy and Orthopedic School, there has been constant growth and extension of services offered. The idea for the School was conceived by a group of

concerned parents of cerebral palsied children. The School opened in January of 1950 in a renovated Army barracks containing 2,500 square feet. A modern 18,000 square foot building now houses the School. Twenty children attended the first session compared with one hundred and five being served in the fall of 1969. The staff has grown from three volunteers and two paid part-time therapists to a professional staff of eighteen plus aides and volunteers. Operating expenses have risen from $59.75 per month during the first session to $116,400 for the year ending December 31, 1969. The original services offered have grown and extended into many different areas. (These will be fully covered in the following chapter.) Thus the history of the Greensboro Cerebral Palsy and Orthopedic School has been a story of expansion in every area.

Chapter III

THE PRESENT OPERATION[29]

Patients Being Served

The Greensboro Cerebral Palsy and Orthopedic School, as of March 1, 1970, is serving one hundred and seven patients. Of this number eighty are full-time day students between the ages of three and sixteen. A classification of patients according to disorders is as follows:

54 - Cerebral Palsied
11 - Spina Bifida
4 - Muscular Dystrophy
3 - Scoliosis
2 - Werdnig-Hoffman's Disease
2 - Arthrogryphosis
1 - Osteochondro Dystrophy
1 - Charto-Marie-Tooth's Disease
1 - Transverse Mylitis
1 - Automobile accident victim

Three of the families with children in the School have more than one child with cerebral palsy. In one instance identical twins are enrolled. A majority of the eighty children receiving treatment have been afflicted since birth. Forty-eight are girls; thirty-two are boys. Sixty-three are

---

[29]Information presented herein was obtained through author observation of classes and facilities of the School and through informal interviews with appropriate staff members. The period of time covered was October 1968 through March 1970.

Caucasoid; seventeen are Negroid. The average age of the day students is nine and one-half years. Most of these children entered the School at preschool age. Approximately two to five children transfer out of the School each year due to reaching the maximum age for day school enrollment (sixteen years), moving out of the Greensboro area, or having received maximum benefit from the School. All economic and social backgrounds are represented in the School. However, a majority of the students come from the lower-middle socio-economic level. At least fifty per cent of the patients have been found to be mentally retarded. This figure would be considerably higher if those who were environmentally retarded were included.

The twenty out-patients currently being served are predominately children under age three and, therefore, are too young for day school admittance. The youngest child is presently eleven months old. Several of the out-patient group have transferred into public schools, but need continued physical or occupational therapy. Speech therapy is not available for the out-patients.

The same seven persons have been served over the past several years in the adult group. One of these patients is mentally retarded and suffers from a general lack of coordination; the other six are cerebral palsied. This group meets one afternoon per week for occupational therapy, including crafts and recreational activities.

At the present time three patients are waiting to be enrolled and three applications are pending. Presently there is not room for all applicants in the preschool program. Between two and four applicants are refused each year. Chief among the reasons for refusal are that the patient is mentally retarded but has no orthopedic involvement, or that the patient is too handicapped to be helped by the School. No patients are refused on the basis of financial inability.

The Staff

The Executive-Director of the Greensboro Cerebral Palsy and Orthopedic School is Mrs. A. M. Inman who is serving her fifteenth year. She holds a Bachelor of Arts degree in Sociology and Psychology. She has taken graduate courses in Child Welfare and Psychology and is currently working toward a Master of Arts in Education at the University of North Carolina-Greensboro. The Assistant Director, Mrs. Little, holds a Bachelor's degree in History. Both of these officials had many years of experience as Board members and volunteer workers in the School prior to accepting their present positions.

Two teachers head the preschool program at the School. One who has had several years of experience in private kindergartens in Charlotte, N. C., and Wurtzburg, Germany, has been employed by the School for the past ten years. The other, employed by the City School System, holds a Master's degree in Primary Education and has had over

twenty years of experience in private kindergarten and public school teaching. She has been teaching at the School for eight years. Each of these teachers is assisted by a full-time aide.

There are eight academic teachers for the School's patients. One trainable group is taught by a young woman who is a graduate in Special Education for whom this is the first year of teaching experience. She is the only teacher in the academic program employed by the Cerebral Palsy School, the others being employees of the City School System. She is assisted by a full-time aide. The other trainable group is taught by a teacher holding a degree in Primary Education and having nine years of experience. One of the teachers is part-time, teaching only typing and home economics. The remaining five teachers all hold degrees in Primary, Elementary, or Special Education and have from one to twenty years of experience. Two aides divide their time as needed between the classrooms. All eight of these teachers, as well as the two preschool teachers, hold North Carolina Class A teaching certificates.

Any physical therapist employed by the School must be a graduate of an approved school of physical therapy and have a North Carolina license to practice physical therapy. The only full-time therapist now employed by the School is a former registered nurse with two years previous experience and eight years experience at the School. A part-time

physical therapist is supplied by the City School System. She holds a Master's degree and has had experience at Duke Hospital in Durham, North Carolina, as well as a year and a half at the School. Three aides, one furnished by the City System, assist in this department.

One full-time speech therapist is supplied to the School by the City System. This is her first year of experience. She is assisted by one full-time aide.

The occupational therapy department is staffed by two full-time therapists. Both have degrees, North Carolina certificates, and have passed National examinations in occupational therapy. One aide and one occupational therapy assistant also work in this department.

A graduate librarian is furnished three days per week by the City System. The entire professional staff of the School is assisted by two secretaries, two janitors, and a cook. All aides have minor cleaning duties also.

Volunteer workers are used in all departments as requested by staff members. At the present time thirty-one persons are volunteering ninety hours weekly in this area. During the summer months, the volunteers are primarily teen-agers, fourteen years and older. Twenty-seven young people served as volunteers during the summer of 1969.

Medical Services

Dr. E. R. Troxler, an orthopedic surgeon, has served as Medical

Director of the Greensboro Cerebral Palsy and Orthopedic School from the time of its establishment. He holds clinics at the School on the average of once every three weeks. He prescribes physical therapy for each child and maintains surveillance of all orthopedic appliances. Some patients at the School are referred to Dr. Winthrop Phelps in Baltimore, Maryland, for periodic check-ups and recommendations for therapy. The School also works closely with the North Carolina Orthopedic Hospital in Gastonia, North Carolina.

Dr. Martha Sharpless, a local pediatrician, holds periodic clinics at the School and examines children at other times when requested to do so by the staff. She also acts as a liaison between the School and private pediatricians. Interns and residents from Moses H. Cone Hospital, Greensboro, North Carolina, who visit the School work under the supervision of Dr. Sharpless.

Dental services for the School are supplied by volunteers from the Guilford County Dental Society. Most of the dental work is done at the School; however, some children are required to visit dentists' offices where voluntary services are performed. Volunteer dental hygenists come to the School to clean and examine teeth as well as to give programs and demonstrations in the various classrooms.

A Public School health nurse visits the School weekly on a year-round basis. She arranges for any needed home follow-up services by

the district health nurses. She also serves as a source of referral for school applicants.

The School works closely with the Crippled Children's section of the North Carolina Board of Health. Through this agency Federal funds are available to provide braces, special appliances, orthopedic shoes, and hospitalization for children from indigent families. Indigent children are also fitted with glasses by the Eye Clinic at the Guilford County Health Department. The Greensboro Lions Club provides glasses for these children financially in need.

Very little volunteer neurological or psychological service is available to the School. A few of the School's patients are seen at hospitals in Winston-Salem, Durham, and Chapel Hill, North Carolina, for psychological and developmental evaluation. The Children and Youth Clinic of the Guilford County Health Department schedules children into doctors' offices and hospitals for necessary tests. Some psychological testing is also available through the City School System. Occasionally psychiatric help is obtained for a given patient through the Guilford County Mental Health Clinic. The Vocational Rehabilitation Agency works with patients fifteen and over for rehabilitative services leading to future employment.

Curriculum

The curriculum of the Greensboro Cerebral Palsy and Orthopedic

School is patterned to fit the needs of each individual as they arise. The School attempts to develop the potentialities of each child as fully as possible within the limits of his disability. All teachers and therapists meet weekly to assess the needs of every individual. Emphasis is placed on allowing each child to explore varied outlets of experience.

Preschool

The principal endeavor of the preschool department is to assist the child in making the break from his home as easily as possible and to prepare him for beginning academic training. Twenty-two day students participate in the preschool program. The children are encouraged to help themselves. The teachers attempt to prevent "dead end" habits--ways the child may develop for performing certain tasks which can never be improved upon. Group participation and sharing, as well as personal independence, are stressed. Each child is helped to make the most of his abilities.

Academic Program

The flexible academic program is designed to satisfy the needs of each child intellectually, emotionally, and socially. The ultimate goal of the program is to help each individual to be the best thinker possible according to his ability. The classes are ungraded through the elementary and junior high school levels. Each child progresses

as he is able in each subject. The children are grouped as to where they are in a particular subject at a given time. The teachers teach various subjects on different levels. Thus the children change classes each thirty minutes and are able to experience a variety of teaching techniques, personalities, and environments.

The School uses an individualized technique for teaching spelling based on the premise that one doesn't spell letter by letter. No lists or books are used, and the child is not asked to spell aloud. Each child selects his own words. As the teacher writes it for him, the child learns to recognize the whole word as he says it aloud. "Check out" is done in dictated sentences given only before the child begins to write. This method of teaching spelling also serves as auditory training and to increase retention abilities.

The daily schedule for one cerebral palsied twelve year old girl is as follows:

Occupational Therapy - Arts and crafts, activities to increase powers of perception and eye-hand coordination. Large mixed class.

Physical Therapy - Exercises to strengthen the muscles used in walking and physical education.

Spelling and Writing - No grade level. Class contains one older and one younger girl.

Mathematics - Third grade level. Class contains one older and one younger child.

Reading - Second grade level. Class contains one other twelve year old girl.

Home Economics - Five other girls of various ages.

Science - Fifth grade level. Nine others of all ages. Teaching is based on experiments with five text books used as research material.

Language - Third grade level. Four others of various ages.

Social Studies - Similar group to science class, but no grade level. The children choose their own topics of study.

Extra Physical Therapy as speech therapy is not needed.

Typing - Mixed group.

Homeroom Period - A congenial group of children with two years of this child's age. Activities include music, physical education, and special projects.

Thus this child has the opportunity to work with ten different teachers and therapists and many other children each day.

The senior high school program follows more closely the normal high school curriculum. By changing classes and working with the different therapists, however, the child still has the opportunity to experience a variety of environments and teaching techniques. Those graduating are given diplomas from the public school which they

ordinarily would have attended. They are eligible for a class ring and participation in all of their school's graduation activities.

Physical Therapy

All of the School's patients receive some form of physical therapy. Each child receives an overall muscular evaluation, is tested for pathological reflexes, is checked for deformities, and is placed on a therapeutic program to fit his individual needs. A combination of four methods of therapy is used. The straight orthopedic approach, developed by Dr. Winthrop Phelps, is based on bracing to keep the extremities in good position and to prevent deformities. Surgical procedures, such as muscle transplants, are used in conjunction with this method. This approach has the disadvantage of the child's being impeded by constant wearing of braces and, therefore, being unable to fully learn to use his own body. The Bobath method is a total treatment procedure based on normal developmental patterns. In this method, patterning is begun when the child is very young (without bracing) before abnormal patterns have developed. This method combines physical therapy, speech therapy, and occupational therapy. The Rood Neurophysiological approach is also based on normal developmental patterns. Here the child is taught to master four stages--not progressing to one until the previous one has been stabilized. These four stages, or positions, are the withdrawal-supine position (the fetal position), the

pivot-prone position, the quadraped position, and the standing position. Knott's proprioceptine neuromuscular facilitation is based on the premise that no muscles work in isolation. Functional movements are based on a rotational pattern. Exercises are begun through muscle and joint stimulation followed by resistance. These four methods of physical therapy are used in various combinations and degrees depending on the therapists' determination of each child's adaptability.

Speech Therapy

Speech therapy concentrates on developing each child's ability to communicate intelligibly. Initial and periodic evaluations are made of all patients, although only approximately thirty per cent are given speech therapy. Speech therapy for the cerebral palsied includes progressing from gross to specific movements, progressing from passive to resisted movements, controlling primitive patterns, working from vegetative to voluntary movements, and posturing. Emphasis is placed upon perception of movement and on working beyond minimal motor requirements. Techniques suited to each child's interests and abilities are used to increase motivation. Achieving and stabilizing the best possible articulatory precision for each individual is the ultimate goal of the speech therapy department.

Occupational Therapy

Eighty-five to ninety per cent of the School's patients receive occupational therapy. The department does not attempt to train patients for any specific job or to find employment for them. Occupational therapy consists of emphasis in three major areas. Coordinated motor development is stressed through activities to increase gross body control, head-arm-hand control, and eye-hand control. Perceptual development activities increase: body orientation, form discrimination, and figure-ground relationship. A major area of concentration is in activities for daily living. The children are taught to feed and dress themselves, to bathe themselves, and other forms of self-care. Typing and home-making skills are a part of this program. Pre-vocational evaluations, group dynamics, and recreation round out the therapy offered in the occupational therapy department.

Co-Curricular Activities

Six patients from the School participate in the Sheltered Workshop program at the Greensboro Community Center. The program offers additional therapy for persons needing occupational training but who cannot progress further academically. It is sponsored by the Vocational Rehabilitation Agency. The participating patients are transported by Workshop personnel to and from the Community Center for one-half of each day. The Workshop was begun, primarily, to train mentally retarded persons for

simple jobs. It is, therefore, not ideal for persons who are physically handicapped by orthopedic disabilities.

Volunteer workers are used in all three therapy departments. They are assigned tasks which they perform under the supervision of the professional therapists. Teachers use volunteers in a variety of ways. Some assist children who are too physically handicapped to write term papers in line with their academic abilities. Some work with children during study periods to assist with homework assignments. Volunteers assist with feeding children in the lunch room, give music lessons, and transport children to medical appointments and on field trips.

Discussion of the School curriculum would be incomplete without mention of the many outside and extra-curricular activities. The School sponsors many field trips to local museums, parks, and governmental facilities. Most of these take place during the summer when more day camp activities are offered. Some of the older children have been taken to visit museums and governmental facilities in Raleigh, North Carolina. Future plans include trips to Old Salem in Winston-Salem and the planetarium in Chapel Hill. Interested organizations and service clubs provide activities such as giving puppet shows, organizing after-school-hours parties, and special holiday events. The local Fire Department sponsors a program on fire prevention featuring films, fire trucks, and the firemen's canine mascot, Sparky. The children attend an ice show

or circus each year as guests of a local businessman. They go to concerts given by the Greensboro and North Carolina Symphonies. Meyer's Department Store, Greensboro, North Carolina, gives a Christmas party each year in their Tea Room. The various activities are enjoyed by those patients whom the staff feels can most benefit.

Special Materials and Equipment

The Greensboro Cerebral Palsy and Orthopedic School receives all academic supplies, a great deal of audiovisual equipment, art supplies, office supplies, and janitorial supplies from the City School System. The audiovisual equipment includes record players, various types of film projectors, projectors used for projecting flat surfaces and transparencies, language masters, talking book machines, and a magnified book viewer. The equipment is used, usually, in the library, but it may also be used in the classrooms and therapy departments. Many organizations and individuals donate large pieces of special equipment.

The preschool classrooms have large sand boxes, multiple standing tables, wooden kitchen appliances, and a great many creative toys. Every classroom contains movie screens, globes, am/fm radios, and large mirrors. The School has a piano on a dolly for transportation to rooms where it is needed.

The speech therapy department has at its disposal an audiometer, tape recorder, record player, a Bell and Howell language master, and a

padded table. Standardized test materials plus various games and toys are available for use in speech therapy activities.

Special equipment in the physical therapy department includes Plinth tables, Elgin exercise tables and wheel chair exercisors, electric, one wheel drive, and reclining wheel chairs, hydraulic lifts, raised and floor exercise mats, parallel bars, standing tables, training steps, and adjustable slides. Tricycles, scooter carts, and plain wheel chairs are also used. Television sets and carpets have been donated to the physical therapy department.

The occupational therapy department contains a shoulder wheel, simple wood working tools, a potter's wheel, a kiln, molds, an electric bed, kitchen appliances, and a small pool table. Special eating utensils and suction cups are used in teaching patients to become proficient in self-feeding. Sewing machines, typewriters, tongs for those patients unable to bend over, "pole cat" rods with hand grips, and triangle pulls are used. The large bathroom contains a tub with a hydraulic lift, three types of seats, and various wall bars throughout. Three different sized toilets and several toilet chairs are here. The shower has several attachments and chairs for the orthopedically handicapped. Electric razors and toothbrushes are available. The bathroom also contains a specially padded table with drawers and safety straps for changing diapers.

The School's library was inventoried as having two thousand four hundred and fifty cataloged books in May of 1969. Since that date fifty-four new books have been added. Including encyclopedias, paper backed books, and old books not in condition for general use, the library contains approximately two thousand eight hundred books in all at the present time.

The School has three medical offices. The doctor's office contains an examining table, an instrument cabinet, first aid equipment, stethescope, blood pressure equipment, and a diagnostic set. The dental office contains a dental chair and an x-ray machine. It is fully equipped for dental procedures, such as cleaning, filling, and ordinary extractions. The third office is the psychologist's office and contains psychological testing materials.

The playground has all of the usual play equipment, including swings, slides, and a see-saw. The School's property being used for a playground is completely fenced in and planted with grass. This area is used on a year-round basis except in inclement weather. Garden clubs have donated a bird bath and several benches to beautify the grounds.

The Physical Plant

The Greensboro Cerebral Palsy and Orthopedic School is housed in a modern, eighteen thousand square foot, brick and cinder block build-

ing located at 1601 Gatewood Avenue. As mentioned in the previous chapter, the building consists of two wings--one completed in 1953, the other in 1964. The wings contain separate oil circulating hot water heating systems and air conditioning systems. The floors of the 1953 sections are asphalt tile on concrete. The 1964 section has terrazzo floors which contain an abrasive aggregate to decrease slippage. The lighting is mainly fluorescent, with some incadescent in the older wing. Large windows permit good outside lighting throughout the structure. The building has acoustical ceilings and pastel colors are used on the walls.

There are two preschool and eight academic classrooms in the building. The physical therapy department occupies two rooms, the speech therapy department occupies two rooms and a small room for audiometric testing, and the occupational therapy department occupies a large L-shaped room with a large teaching bath. The School's kitchen is stainless steel and meets the standards set by the State and County Health Departments. A large dining room adjoins the kitchen. The building contains offices for the director, assistant director, doctor, dentist, social worker, prevocational guidance counselor, and psychologist plus a reception area and a business office. The library is adequately large. There are six bathrooms for children, one being the teaching bath, all with different sized toilets. Other bathrooms are available for the staff. Storage rooms are situated in both sections of the

building.

A patio opens off the physical therapy department which also serves as a ramp to the play area. A walkway surrounds the new wing, and all of the rooms have an outside entrance. The grounds contain one play shelter with storage space and two permanent storage shelters.

Financial Information

The major financial backing for the Greensboro Cerebral Palsy and Orthopedic School comes from the United Fund. For instance, the United Fund contributed $9,124 for January 1970. The School's budget does not include services, materials, and equipment contributed by the City School System. Reimbursement received under the Federal lunch program is included in the total budget.

The current tuition for day students is $20 per month. Out-patients pay up to $5 per treatment. Most of the clients, who are able, pay $3 per treatment. The adult patients are charged the nominal sum of fifty cents monthly for all services received. Lunch fees are forty cents per day for patients and forty-five cents per day for staff.

For the month of January 1970, the budget report showed $10,201.01 in receipts and $9,047.27 in disbursements. The summary financial report for the month ending January 31, 1970 was:

	Balance 12/31/69	Receipts	Disbursements	Balance 1/31/70
General Fund	.00	10,201.01	9,047.27	1,153.74
Special Purposes	31,865.05	3,345.08	334.13	34,876.00
Petty Cash	150.00	.00	.00	150.00
	32,015.05	13,546.09	9,381.40	36,179.74

The Special Purpose Fund derives its resources primarily from donations, memorial gifts, and contributions toward capital improvements. At the present time it contains contributions toward the Scholarship Fund. The School's Executive-Director hopes to have a separate Scholarship Fund set up within the near future.

Summary

As of March 1, 1970, the Greensboro Cerebral Palsy and Orthopedic School is serving one hundred and seven patients, most of whom are cerebral palsied, although patients with a variety of orthopedic involvements are accepted. Some of this number are children and adults who are served on an out-patient basis. Many of the children are mentally retarded and most come from the lower middle socio-economic level. The staff includes qualified directors, teachers, and therapists. Physical, speech, and occupational therapies are offered in addition to a full preschool and academic program through the high school level. Orthopedic, pediatric, and dental services are available at the School.

The School has a variety of special materials and equipment to meet the needs of the patients being served. The School is located at 1601 Gatewood Avenue in a modern eighteen thousand square foot building. Major financial backing is received through the United Fund, although there are tuition and therapy charges. The School receives further services, materials, and equipment from the Greensboro, North Carolina, City School System. The School's proposed budget for the year 1970 estimates operating expenses as slightly over $146,000.

Chapter IV

CONCLUSION

Summary

Cerebral palsy is one of society's most complicated and prevalent disorders. Cerebral palsy is a term used to cover individuals handicapped by motor disorders which are due to non-progressive abnormalities of the brain. The specific symptoms of cerebral palsy depend upon where in the brain the lesion is located. The lesion(s) may be the result of prenatal, natal, or postnatal factors. Special tests have been devised to assess brain damage. Cerebral palsy can be classified according to major physiological groups, on the basis of neuromuscular characteristics, on the basis of topography, or according to therapeutic needs. Consideration must be given to the many related disorders. As the modern approach to treatment of cerebral palsy calls for a team of specialists in various areas, information on cerebral palsy's nature, causes, and classification system is useful to many persons.

The Greensboro Cerebral Palsy and Orthopedic School is now in its twentieth year of operation. The idea for a school was conceived by local parents of cerebral palsied children. These parents organized the Greensboro Cerebral Palsy Association in March 1949. In January of

1950, the School began part-time operation in a renovated Army barracks. This two thousand five hundred square foot building was used for three years. In 1953 a new nine thousand square foot structure was completed at 1601 Gatewood Avenue. An additional nine thousand square feet were added in 1964 which gives the present facility eighteen thousand square feet. Twenty cerebral palsied children were served by the School in 1950. This number has risen to a total of one hundred and seven day students, out-patients, and adults being served in March 1970. The School began serving other orthopedically handicapped individuals in 1964. The staff in 1950 consisted of three volunteers and two paid part-time therapists. Today there is a professional staff of eighteen plus aides and volunteers. Operating expenses were estimated to be $59.75 per month in the spring of 1950. The proposed budget for the year 1970 estimates that total disbursements will be over $146,000. This figure does not include the services, equipment, and materials furnished by the Greensboro City School System. The major financial assistance to the School comes through the United Fund although there are tuition and therapy charges. Fees are assessed from families of clients who are able to accept this responsibility.

In 1950 the curriculum included preschool training, a small academic class, and limited physical and speech therapy activities. Today there are two preschool classes and eight academic classes, each

staffed by a certified teacher. A full program of physical, speech, and occupational therapy is available. Orthopedic, pediatric, and dental clinics are held regularly on the campus. The School works closely with local welfare agencies and medical groups in order to provide each child with all possible aid. The Greensboro Cerebral Palsy and Orthopedic School's history of steady growth and expansion of services is one indication of its contribution to the community.

Limitations of the Study

This study has dealt with the establishment of a much-needed day care center by parents of cerebral palsied children. These parents began operating without a full professional staff or adequate financial backing. Services offered were quite limited. The fact that these loosely organized efforts have proven successful is rather amazing.

The writer has not attempted to compare the Greensboro Cerebral Palsy and Orthopedic School with any other institution. The School is unique in this geographical area, in that it serves the cerebral palsied population as well as other orthopedically handicapped individuals. Comparison cannot be made between this school and institutions which offer residential care and/or hospitalization. As the School is supported by community contributions and by the North Carolina Department of Education, it should not be compared with private facilities.

No attempt has been made to evaluate the School. A researcher

more knowledgeable in every area would be needed to evaluate the quality of the academic program and the individual therapies. Unavailability of data made determination of the exact number of orthopedically handicapped persons in the Greensboro area impossible.

It should be noted, however, that the School does not refuse services to any individual due to inability to make payment. The completeness of the School's services to the orthopedically handicapped of Greensboro, North Carolina (population approximately one hundred fifty thousand) is evidenced by the fact that only six people are on the waiting list for admission.

BIBLIOGRAPHY

Allen, Robert M., and Jefferson, Thomas W. Psychological Evaluation of the Cerebral Palsied Person. Springfield, Illinois: Charles C. Thomas, 1962.

Bennett, Minnie. We Will Win. (private publication)

Carrell, James A. Disorders of Articulation. Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1968.

Crothers, Bronson, and Paine, Richmond S. The Natural History of Cerebral Palsy. Cambridge, Massachusetts: Harvard University Press, 1959.

Cruickshank, William M., et al. Perception and Cerebral Palsy. Syracuse, New York: Syracuse University Press, 1965.

Cruickshank, William M., and Raus, George M. Cerebral Palsy: Its Individual and Community Problems. Syracuse, New York: Syracuse University Press, 1955.

Denhoff, Eric, and Robinault, Isabel Pick. Cerebral Palsy and Related Disorders. New York: McGraw-Hill Book Company, Inc., 1960.

Gellis, Sydney S., and Kagan, Benjamin M., ed. Current Pediatric Therapy. Philadelphia: W. B. Saunders Company, 1968.

McDonald, Eugene T., and Chance, Burton. Cerebral Palsy. Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1964.

Perlstein, Meyer A., ed. Neuropediatrics. Philadelphia: W. B. Saunders Company, 1960.

Phelps, Winthrop M., Hopkins, Thomas W., and Cousins, Robert. The Cerebral Palsied Child. New York: Simon and Schuster, Inc., 1958.

Reilly, William A., and Hughes, James G., ed. Pediatric Endocrinology - Brain Damage in Children. Philadelphia: W. B. Saunders Company, 1957.

Reports

Abbott, Marguerite. Cerebral Palsy. Report to the Public Affairs Commission of New York. New York, 1956. Public Affairs Pamphlet No. 158a.

The Cerebral Palsy School of Greensboro, North Carolina. Annual Meeting, Board Minutes, 1951-1969. (Typewritten.)

The Greensboro Palsy School of Greensboro, North Carolina. Contributors to the Greensboro Cerebral Palsy School, monthly 1951-1969. (Typewritten.)

The Cerebral Palsy School of Greensboro, North Carolina. Greensboro Cerebral Palsy Association, Inc., Statement of Receipts and Disbursements, monthly 1951-1969. (Typewritten.)

The Cerebral Palsy School of Greensboro, North Carolina. Minutes of Cerebral Palsy Board, Organization Meetings, 1951-1969. (Typewritten.)

The Cerebral Palsy School of Greensboro, North Carolina. Report on Study of Purposes, Programs and Finances, 1964. (Typewritten.)

The Cerebral Palsy School of Greensboro, North Carolina. Statistical Reports, 1951-1969. (Typewritten.)

The Cerebral Palsy School of Greensboro, North Carolina. Treatment Records, 1951-1969. (Typewritten.)

GREENSBORO CEREBRAL PALSY SCHOOL
1601 Gatewood Avenue
Greensboro, North Carolina

Statement of Policies

I. PURPOSE:

The purpose of the Greensboro Cerebral Palsy School is to assist each orthopedically handicapped individual with whom it works to develop his potentialities as fully as possible within the limitations of his handicap.

II. POLICIES:

1. Enrollment:

(a) Only those individuals who in the best judgement of staff, Medical Director and the Admissions Committee are able to receive benefit from the services that the School has to offer will be admitted or continued in the School.

(b) Individuals of any age may be accepted for certain services.

(c) In order to utilize most effectively the space and staff, it will be the policy of the School to continue to have the staff and the Admissions Committee review all enrollees at least once each year.

(d) Each child's enrollment shall be for the current year only, and re-enrollment shall be determined by the Admissions Committee upon written application from the parent, and based upon clinical and staff reports and upon facilities of the School.

(e) If at any time after one month of his original enrollment the staff finds that a child is unable to benefit from the services of the School, is unable to fit into the group, or needs excessive attention, or if the parents are not making every effort to see

that the child attends regularly, the Board may request the parents to withdraw the child from the School.

(f) The Cerebral Palsy School will continue to transfer all children possible to public school and other institutions as soon as their needs can be met by these resources.

(g) The Cerebral Palsy School will continue to be made available to orthopedically handicapped children other than the cerebral palsied, so long as space is available and other requirements are met to the satisfaction of the Board of Directors of the Association. (Adopted 4-23-65)

2. Fees:

(a) A fee similar to that of public schools shall be charged for lunches and books. In addition, therapy fees shall be charged on the following basis:

$10.00 per month for (1) therapy
$15.00 per month for (2) therapies (i.e. Physical and Occupational Therapy)
$20.00 per month for (3) therapies

Therapy fees for out-patients shall be $3.00 per treatment, not to exceed the monthly maximums, above. As space permits, students from outside the Greater Greensboro area may be accepted on a fee basis, such fee to be determined by the Finance Committee. (10-15-65)

(b) No individual is denied service because of inability to pay. Arrangements for payment or necessary adjustments of all fees shall be made (in advance) with the Director.

3. Applications:

(a) Only children whose orthopedic handicaps make it difficult or impossible for them to receive needed services elsewhere may be accepted.

(b) Applications shall be made on a form provided by the School and must be accompanied by a Medical Examination blank signed by the Medical Director or by members of a Medical Committee designated by him. Such applications will be considered in the order of completion and as far as possible, applicants will be admitted in the order of application.

The Admissions Committee is authorized to make final decision on all applications for enrollment.

(c) All children at the Cerebral Palsy School shall be examined at least twice annually by the Medical Director of the School or by physicians designated by him.

4. Services:

The services of the School shall include preschool and school instruction, physical therapy, speech therapy, occupational therapy, arts and crafts, medical and psychological testing, and parental counseling.

5. Residence:

Preference is given to residents of the Greater Greensboro Area. However, other applicants may be accepted upon condition that space is available.

6. Financing:

The Board of the Cerebral Palsy School shall continue to study additional sources of permanent financing to supplement the School's present support.

EXECUTIVE DIRECTORS OF GREENSBORO CEREBRAL PALSY AND ORTHOPEDIC SCHOOL

Dr. J. A. Highsmith	Sept. 1953 - Sept. 1954
Mrs. Homer Coltrane	Sept. 1954 - Oct. 1955
Mrs. A. M. Inman	Oct. 1955 - Present

PRESIDENTS OF GREENSBORO CEREBRAL PALSY AND ORTHOPEDIC SCHOOL BOARD OF DIRECTORS

Mr. W. H. Holderness	1950-1953
Mr. Edward Loewenstein	1953-1954
Mrs. W. D. Graham, Jr.	1954-1955
Mr. Robert Lloyd	1955-1957
Mr. Michaux Crocker	1957-1958
Mrs. A. T. Preyer, Jr.	1958-1960
Mr. Sion Boney	1960-1962
Mrs. Robert Little	1962-1965
Mr. William Elmore, Jr.	1965-1967
Mr. Park Davidson	1967-1970
Mrs. John McIver	1970

1962

BY-LAWS OF

GREENSBORO CEREBRAL PALSY ASSOCIATION, INCORPORATED

ARTICLE I

Membership

Each individual who makes any contribution whatever to the Association in any calendar year, either in money or in service, shall be a member of the Association for the calendar year in which such contribution is made. Each individual who at the time is a parent of a cerebral palsied child and a resident of Greensboro, North Carolina, shall be a member of the Association for the then current calendar year.

ARTICLE II

Meetings of Members

Section 1. The annual meeting of the members shall be held in Greensboro, North Carolina, on the third Friday in June in each and every year (or if said date be a legal holiday, then on the next succeeding business day) for the purpose of electing directors and of transacting such other business as may be properly brought before the meeting.

Section 2. Special meetings of the members shall be held in Greensboro, North Carolina, upon call of the Board of Directors, or the President, or in the absence of the President, upon call of a Vice President, the Secretary or the Treasurer, at such time as may be fixed and stated in the call and notice.

Section 3. Notice of the time, place and purpose of every meeting of the members shall be given by the Secretary by causing the same to be published in a daily newspaper published in Greensboro, North Carolina, at least one week prior to the date of such meeting.

Section 4. Nine members of the Association shall constitute a quorum at any annual or special meeting of the members of the Association.

ARTICLE III

Board of Directors

Section 1. The Board of Directors shall have general power to direct the management of the business and affairs of the Association and may adopt such rules and regulations as it shall deem proper, not inconsistent with the law or these by-laws for the conduct of its meetings and for the management of the affairs and the business of the Association.

Section 2. The number of the directors shall be thirty. At each annual meeting of the members ten directors shall be elected for a term of three years. At least a majority of the directors of the Association shall be actual residents of Greensboro, North Carolina. No member shall be elected for more than two successive three-year terms. The only exception shall be the immediate past president who may serve one additional year. Any officer not elected from the Board membership may serve as a Board member as long as he holds office, regardless of the total number of Directors.

Section 3. The annual meeting of the Board of Directors shall be held in Greensboro, North Carolina, each year immediately after the adjournment of the annual meeting of the members. If a quorum of directors be not present for the annual meeting of the Board of Directors, the meeting shall be adjourned to some convenient day. No notice need be given of the annual meeting of the Board of Directors.

Section 4. Regular monthly meetings of the Board of Directors shall be held on the third Friday in each month, except during July and August, at such place as may from time to time be fixed by resolution of the Board of Directors after oral, telegraphic or written notice, duly served on or sent or mailed to each director not less than two days before such meeting.

Section 5. Special meetings of the Board of Directors may be held at any time upon the call of the President, or a Vice President, or any two directors, by oral, telegraphic, or written notice of the time, place and purpose of such meeting, duly served on or sent to or mailed to each director not less than two days before such meeting.

Section 6. The attendance of one-third or more of the directors at the time qualified and acting as such shall constitute a quorum for the transaction of business at any annual, regular or special meeting of the

Board of Directors.

Section 7. In addition to the powers and authorities expressed or conferred upon by these by-laws, the Board of Directors may exercise all such powers of the Association and do all such lawful acts and things as are not by statute or by the Certificate of Incorporation of the Association, or by these by-laws, directed or required to be exercised or done by the members.

Section 8. Any director of the Association may resign at any time by giving written notice to the President, or to the secretary of the Association, and such resignation shall take effect at the time specified therein, and unless otherwise specified therein the acceptance of such resignation shall not be necessary to make it effective.

Section 9. Vacancies in the Board of Directors may be filled by a vote of the majority of the directors then in office. Any director so chosen shall hold office during the balance of the term of his or her predecessor.

ARTICLE IV

Committees

Section 1. The Board of Directors may designate an Executive Committee to consist of the President, the Vice President or Vice Presidents, the Secretary and the Treasurer of the Association. The Executive Committee shall have and may exercise, as far as may be permitted by law, all of the powers of the Board of Directors in the direction of the management of the business and affairs of the Association during the intervals between meetings of the Board of Directors, but the Executive Committee shall not have power to fill vacancies in the Board of Directors or the change of membership of or fill vacancies in the Executive Committee or to make or amend the by-laws of the Association. The Board of Directors shall have the power at any time to fill vacancies in, change the membership of, or dissolve the Executive Committee. The Executive Committee may hold meetings and make rules for the conduct of its business and appoint such Committees and assistants as it shall from time to time deem necessary. A majority of the members of the Executive Committee shall constitute a quorum and determine its action.

Section 2. The Board of Directors may appoint other Committees which shall have and may exercise such powers as shall be conferred or authorized by the resolution appointing them. A majority of any such

Committee may determine its action and fix the time and place of its meetings unless the Board of Directors shall provide otherwise. The Board of Directors shall have the power at any time to fill vacancies in, change the membership of or dissolve any such Committee.

ARTICLE V

Officers

Section 1. The Board of Directors at its annual meeting shall elect a President, one or more Vice Presidents, a Secretary and a Treasurer of the Association, and may from time to time appoint Assistant Secretaries, Assistant Treasurers, and such other officers, agents and employees of the Association, including an Executive Director, as it may deem proper. The President and the Vice President or Vice Presidents shall be chosen from among the directors but the other officers of the Association need not be directors.

Section 2. The term of office of all officers shall be for one year or until their respective successors are chosen but any officer or agent elected or appointed by the Board of Directors may be removed with or without cause at any time by the affirmative vote of the majority of the members of the Board of Directors then in office.

Section 3. The officers, agents and employees of the Association shall have such powers and duties in the management of the business and affairs of the Association, subject to the control of the Board of Directors as generally pertain to their respective offices as well as such powers and duties as from time to time may be prescribed by the Board of Directors. The President shall preside over all meetings of the members and over all meetings of the Board of Directors. The secretary shall record all the proceedings of the meetings of the members, and the meetings of the Board of Directors, in a book to be kept for that purpose.

Section 4. In case of the absence of any officer of the Association, or for any reason which the Board of Directors may deem sufficient, the Board of Directors may delegate the power or duties of such officer to any other officer or to any director for the time being, except such powers and duties as are required by law to be performed by such officer.

ARTICLE VI

Finances

Section 1. The monies of the Association shall be deposited in such bank or banks and in such account or accounts as the Board of Directors from time to time shall determine.

Section 2. All checks and drafts on the Association's bank accounts and all payments of exchange and promissory notes, and all acceptances, obligations and other instruments for the payment of money shall be signed in the name of and on behalf of the Association by such officer or officers or agent or agents as shall be authorized from time to time by the Board of Directors.

Section 3. The funds of the Association shall be used to engage in, and to aid the study of and research in problems of cerebral palsied persons and the training, treatment and teaching of cerebral palsied persons, and the establishment, equipment and maintenance of facilities for such purposes.

ARTICLE VII

Corporate Seal

The corporate seal of the Association shall be circular in form and shall have inscribed thereon the name of the Association and such other appropriate legend as the Board of Directors may from time to time determine. In lieu of the corporate seal when so authorized by the Board of Directors, a facsimile thereof may be impressed or affixed or reproduced.

ARTICLE VIII

Fiscal Year

The fiscal year of the Association shall begin on the first day of January in each year and shall end on the thirty-first day of the following December.

ARTICLE IX

Amendments

The by-laws of the Association may be amended, altered, added to or repealed at any annual meeting of the members or at any special meeting of the members if notice of the proposed change is given in the notice of any such special meeting. The Board of Directors may from time to time by vote of the majority of the whole Board of Directors amend or alter the by-laws of the Association at any regular or special meeting at which all of the Directors are present or for which notice of the proposed change is given or served, subject, however, to the power of the members to amend, alter or repeal any by-laws made by the Board of Directors.

1966

BY-LAWS OF

GREENSBORO CEREBRAL PALSY ASSOCIATION, INCORPORATED

ARTICLE I

Membership

There shall be no members of the Corporation.

ARTICLE II

Board of Directors

Section 1. The Board of Directors shall have general power to direct the management of the business and affairs of the Association and may adopt such rules and regulations as it shall deem proper, not inconsistent with the law or these by-laws for the conduct of its meetings and for the management of the affairs and the business of the Association.

Section 2. The number of the directors shall be at least thirty. At each annual meeting of the directors at least ten directors shall be elected for a term of three years. At least a majority of the directors of the Association shall be actual residents of Greensboro, North Carolina. No director shall be elected for more than two successive three-year terms, except that the immediate past president may serve one additional year. Any officer not elected from the Board membership may serve as a Board member as long as he holds office.

Section 3. In addition to the powers and authorities expressed or conferred upon it by these by-laws, the Board of Directors may exercise all such powers of the Association and do all such lawful acts and things as by statute may be exercised or done by the members of a similar non-profit organization having members.

Section 4. Any director of the Association may resign at any time by giving written notice to the President, or to the Secretary of the Association, and such resignation shall take effect at the time specified therein, and unless otherwise specified therein the acceptance of such

resignation shall not be necessary to make it effective.

Section 5. Vacancies in the Board of Directors may be filled by a vote of the majority of the directors then in office. Any director so chosen shall hold office during the balance of the term of his or her predecessor.

ARTICLE III

Meetings of Directors

Section 1. The annual meeting of the Board of Directors shall be held in Greensboro, North Carolina, on a day in January to be designated each year by the Executive Committee. If a quorum of directors be not present for the annual meeting of the Board of Directors, the meeting shall be adjourned to some convenient day. No notice need be given of the annual meeting of the Board of Directors.

Section 2. Regular monthly meetings of the Board of Directors shall be held each month except during July and August on a day to be designated by the President, at such place as may from time to time be fixed by resolution of the Board of Directors after, oral, telegraphic or written notice, duly served on or sent or mailed to each director not less than two days before such meeting.

Section 3. Special meetings of the Board of Directors may be held at any time upon the call of the President, or a Vice-President, or any two directors, by oral, telegraphic, or written notice of the time, place and purpose of such meeting, duly served on or sent to or mailed to each director not less than two days before such meeting.

Section 4. The attendance of one-third or more of the directors at the time qualified and acting as such shall constitute a quorum for the transaction of business at any annual, regular or special meeting of the Board of Directors.

ARTICLE IV

Committees

Section 1. The Board of Directors may designate an Executive Committee to consist of the President, the Vice-president or Vice-Presidents, the Secretary and the Treasurer of the Association, and such other persons as the Board of Directors may designate from its member-

ship. The Executive Committee shall have and may exercise, as far as may be permitted by law, all of the powers of the Board of Directors in the direction of the management of the business and affairs of the Association during the intervals between meetings of the Board of Directors, but the Executive Committee shall not have power to fill vacancies in the Board of Directors or the change of membership of or fill vacancies in the Executive Committee or to make or amend the by-laws of the Association. The board of Directors shall have the power at any time to fill vacancies in, change the membership of, or dissolve the Executive Committee. The Executive Committee may hold meetings and make rules for the conduct of its business and appoint such Committees and assistants as it shall from time to time deem necessary. A majority of the members of the Executive Committee shall constitute a quorum and determine its action.

Section 2. The President may appoint other Committees which shall have and may exercise such powers as shall be conferred or authorized by the resulution appointing them. A majority of any such Committee may determine its action and fix the time and place of its meetings unless the Board of Directors shall provide otherwise. The President shall have the power at any time to fill vacancies in, change the membership of or dissolve any such Committee.

ARTICLE V

Officers

Section 1. The Board of Directors at its annual meeting shall elect a President, one or more Vice-Presidents, a Secretary and a Treasurer of the Association, and such other officers as it may deem proper. The President and the Vice-President or Vice-Presidents shall be chosen from among the directors but the other officers of the Association need not be directors.

Section 2. The term of office of all officers shall be for one year or until their respective successors are chosen but any officer or agent elected or appointed by the Board of Directors may be removed with or without cause at any time by the affirmative vote of the majority of the members of the Board of Directors then in office.

Section 3. The officers, agents and employees of the Association shall have such powers and duties in the management of the business and affairs of the Association, subject to the control of the Board of Directors, as generally pertain to their respective offices as well as such

powers and duties as from time to time may be prescribed by the Board of Directors. The President, or in his absence the First Vice-President, shall preside over all meetings of the Board of Directors. The Secretary shall record all the proceedings of the meetings of the Board of Directors, in a book to be kept for that purpose.

Section 4. In case of the absence of any officer of the Association, or for any reason which the Board of Directors may deem sufficient, the Board of Directors may delegate the power or duties of such officer to any other officer or to any director for the time being, except such powers and duties as are required by law to be performed by such officer.

ARTICLE VI

Executive Director

Section 1. There shall be an Executive Director, who shall be a compensated employee appointed by and serving at the will of the Board of Directors. The compensation of the Executive Director shall be determined by the Board of Directors.

Section 2. The duties of the Executive Director shall be the general management of the operations and affairs of the Association, under the direction of the Board of Directors and the President, and also such other duties and responsibilities as may be assigned by the Board of Directors from time to time.

ARTICLE VII

Finances

Section 1. The monies of the Association shall be deposited in such bank or banks or savings and loan associations and in such account or accounts as the Board of Directors from time to time shall determine.

Section 2. All checks and drafts on the Association's bank accounts and all payments of exchange and promissory notes, and all acceptances, obligations and other instruments for the payment of money shall be signed in the name of and on behalf of the Association by such officer or officers or agent or agents as shall be authorized from time to time by the Board of Directors.

Section 3. The funds of the Association shall be used solely for the objects and purposes for which the Association is organized as set

out in the charter.

ARTICLE VIII

Corporate Seal

The corporate seal of the Association shall be circular in form and shall have inscribed thereon the name of the Association and such other appropriate legend as the Board of Directors may from time to time determine. In lieu of the corporate seal, when so authorized by the Board of Directors, a facsimile thereof may be impressed or affixed or reproduced.

ARTICLE IX

Fiscal Year

The fiscal year of the Association shall begin on the first day of January in each year and shall end on the thirty-first day of the following December.

ARTICLE X

Amendments

The Board of Directors may from time to time by vote of the majority of the whole Board of Directors amend or alter the by-laws of the Association at any regular or special meeting at which all of the Directors are present or for which notice of the proposed change is given or served.

GREENSBORO CEREBRAL PALSY AND ORTHOPEDIC SCHOOL

ANNUAL STATISTICAL REPORT - 1969

	1965	1966	1967	1968	1969
Treatments Given:					
Physical Therapy	9,628	10,742	12,490	12,563	14,760
Occupational Therapy...	8,007	10,234	9,160	11,712	13,518
Speech Therapy	3,114	2,866	1,768	2,863	3,496
Academic Classes	36,187	44,875	58,081	60,887	67,971
Preschool Activities	5,412	6,727	8,858	9,005	10,495
Total Treatments Given	62,348	75,444	90,357	97,030	110,240
Clinic Examinations:					
Orthopedic	195	178	208	160	215
Brace	140	87	98	50	108
Shoe	77	50	62	45	83
Dental	10	74	18	97	153
Pediatric	--	--	42	22	51
Total Clinic Examinations	422	389	428	374	610
Individuals Served:					
Day School	73	76	80	84	89
Outpatient Therapy.....	23	22	20	20	25
Adult Group	7	8	8	8	8
Applications for Admission	27	20	18	26	17
New Applicants Approved	17	15	16	24	12
Admissions	21	15	13	15	16
Total Individuals Served	95	97	100	104	118
Change in Status:					
Transferred during year -					
Outpatient to Day School	5	10	6	4	1
Day School to Outpatient	-	-	-	-	3
To Other Agencies	4	1	5	4	3
Graduated	2	-	-	-	-
To Public School.....	-	-	2	3	5
Dropped:					
Non-Attendance	2	4	3	-	2
Maximum benefit	1	-	-	-	-
Other	-	1	5	3	2
Moved	-	6	1	-	2
Total Change in Status ..	14	22	22	14	18
Residence:					
City of Greensboro	57	64	70	63	74
Guilford County (outside Greensboro) ...	37	32	28	37	39
Out of County	1	1	2	4	5
Total Residence.....	95	97	100	104	118

GREENSBORO CEREBRAL PALSY ASSOCIATION, INC.

Budget 1970

General Fund:	
Cash Balance - beginning of period	$ .00
Cash Receipts:	
Food service	4,000.00
Therapy program	5,000.00
United Fund	109,494.00
Other income	27,544.00
Dental program	.00
Total Receipts	$ 146,038.00
Cash Disbursements:	
Wages and salaries	$ 108,632.00
Retirement	12,652.00
Workmen's Compensation	300.00
F.I.C.A.	5,504.00
Communication and postage	1,200.00
Insurance	1,200.00
Auto allowance	150.00
Office supplies	250.00
Travel	400.00
Building and equipment	3,000.00
Laundry	700.00
Heat, lights and water	4,750.00
Food service	4,800.00
Program supplies.....	2,000.00
Other administrative expenses	500.00
Total Disbursements	$ 146,038.00

- -

Special Purpose Fund - December 31, 1969 .. $ 31,865.05

GREENSBORO CEREBRAL PALSY SCHOOL
1601 Gatewood Avenue

GREENSBORO, NORTH CAROLINA

HOW DOES THE COMMUNITY BENEFIT FROM THE CEREBRAL PALSY SCHOOL?

I. Benefits to Individual Citizens

A. The Cerebral Palsied Child benefits in that he

1. Learns to develop his maximum physical capacities through

Exercise and reeducation of muscles;
Control of involuntary motion;
Instruction and practice in walking, climbing, standing, manipulating a wheel chair, getting in and out of bed, chairs, etc.;
Preventing contractures and deformities through proper seating, bracing, etc.

2. Is taught activities for daily living (ADL)

Self-Feeding - a child who learns to feed himself saves a minimum of 2 hours a day, or 14 hours a week or 18 40-hour weeks per year for those caring for him!
Self-Grooming;
Dressing and undressing; putting on and taking off braces;
Caring for toilet needs.

3. Learns and improves methods of communication with others through

Speech,
Writing,
Typing.

4. Is able to profit from opportunities for mental development through

   Academic subjects: reading, writing, arithmetic, nature study, science, etc. - all of the public school curriculum from which he can benefit;
   Enrichment program: music, art, dramatics, creative play, games, recreation, etc.

5. Learns to improve his social relationships through

   Group experiences, which he might never otherwise have;
      Sharing,
      Taking turns,
      Using good manners,
      Helping others;
   Discipline and guidance in useful, acceptable conduct;

6. Develops social maturity by

   Building self-confidence; giving him hope;
   Being prevented from unnecessary dependence on others;
   Being discouraged from feeling that only one or two family members can do things which must be done for him;
   Being provided with the only place where being handicapped is "normal" and where he may succeed at some things.

7. Learns pre-vocational skills through

   Developing body control;
   Perfecting arm, hand, and finger dexterity and skills;
   Developing hobbies and interests.

8. Develops recreational interests and outlets through

   Games, crafts, music, art, trips, etc.

9. Remains a part of his own family group where he can receive the love, attention and security which only a family can give.

10. Develops the tools he needs to live his life to its fullest;

    Perfects the skills he needs to be happy within his physical capabilities.

11. Is enabled to move on to public school, to other special schools, to an institution, or into normal groups, having had an opportunity at the right age to develop his potentialities to the fullest.

B. The Parents of the Cerebral Palsied Child benefit because the School

1. Teaches the parents how to help their handicapped child.

2. Allows parents the satisfaction of knowing that they are providing their child with a normal home life plus proper treatment at the time he can most benefit.

3. Provides emotional relief by having skilled and especially trained persons also watching the child's development and needs.

4. Provides a break in the parents' 24 hour attention to the child.

5. Enables them to share their time with their other children.

6. Often enables the mother to take a paid job and add to family income.

7. Helps the family let the child grow up doing as much for himself as possible.

C. Other children in the family of the cerebral palsied child benefit because the School enables them

1. To have a share of their parents' time.

2. To have a more normal and a more pleasant home life because of the cerebral palsied child's improved social behavior.

3. To understand and accept the cerebral palsied child better

because of his accomplishments, his improved attitude, and personality.

4. To develop the concept that even persons with limited capacities can be useful citizens if they are encouraged to use their abilities to the fullest.

II. Benefits to the Community as a Whole.

Greensboro and its taxpayers benefit from the Cerebral Palsy School because

A. The cerebral palsied individual may learn to fit into a normal group and eventually need no special services.

B. The cerebral palsied individual may become fully or partially self-supporting.

C. The family of the cerebral palsied individual may become self-supporting.

D. The cerebral palsied individual will

become easier to care for,
require less assistance,
become less of a burden,
accomplish more on his own, and
become less expensive to care for.

E. The more severely cerebral palsied may be able to stay out of state institutions where they would be the financial responsibility of the tax payer.

F. Greensboro can take great satisfaction in providing for the special needs of this group of handicapped citizens.

G. The Greensboro School was one of the first of its kind and is constantly visited by those from other communities who are beginning to consider similar programs for their handicapped.

H. Greensboro can be justly proud of this concrete example of its humanity and of its concern for <u>all</u> its citizens. No one can visit the Greensboro Cerebral Palsy School and not realize that Greensboro is a good place to live.