

MAKING A DIFFERENCE

CARING FOR THE INFANT PRENATALLY EXPOSED TO ALCOHOL AND DRUGS

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Foster and adoptive parents frequently find themselves caring for a child who has been affected by prenatal exposure to drugs and alcohol. National data show that 8.5% of pregnant women use illicit drugs, 20.4% drink alcohol, and 22.4% smoke cigarettes. Among children in out-of-home placement within the Child Welfare System in many states, close to 80% of children are born to families with problems related to substance abuse. On top of this, it frequently is difficult to find the kind of help foster and prospective adoptive parents need in the day-to-day care of infants who have been prenatally exposed to alcohol and drugs.

The purpose of this booklet is to give all caregivers some help understanding the substance-exposed child and some practical guidance for addressing the difficulties the infant faces.

The Big Picture

Children in foster or adoptive care often have had a rough start in life.

While the risks that their backgrounds pose often capture the most attention, it is important to also consider the strengths that these children can bring into their new home. The source of this resiliency may be extra attention received from a particular foster parent or relative before he has come into your life, or it may be the child's inherent personality or his innate intelligence. Whatever the case, it is essential to remember that a foster or adopted child, just like every other member of the family, brings strengths and weaknesses, joys and challenges, successes and frustrations into the family. Ultimately, it is the love that the child brings and receives which defines the new family that is created with each adoption.

Of course, the "success" of any placement is a function of not only the capabilities and needs of the child, but also the expectations, characteristics, and lifestyle of the caregiving family members. It is important that foster and adoptive families assess their tolerance for uncertainty, for the potential challenges that the child may bring, and the new parents' ability (financial and otherwise) to modify their lifestyle in order to accommodate the demands of a child who may be quite challenging. Along these lines, a key purpose of this booklet is to enlighten prospective foster or adoptive parents as to what may be required of them as they take on the responsibility for a child with prenatal exposure to alcohol or drugs whose needs will unfold over time.

Making a Difference cannot make the decision of whether you should adopt a particular child. Ultimately, only you can make that decision. What this booklet can do is provide you with information based on the most recent research and clinical experience in regard to children who have been prenatally exposed to alcohol and/or drugs and are in a placement outside their biological home. The information you gather will support you in making the best decision possible for your family. While there are no guarantees when considering adding to a family, the more informed you are, the better able you will be to guide yourselves and your family toward a positive adoptive experience.

Risk Factors at Birth

What are the risk factors prospective parents must consider in the newborn period if the baby was exposed to drugs or alcohol? There are six important ones:

Poor growth

The average birth weight of babies in the United States is 7 pounds 8 ounces, with a normal range down to about 5 pounds 8 ounces. Any baby weighing less than 5 pounds 8 ounces is a "low birth weight" baby. Poor growth in the womb is among the most frequently cited problems occurring among substance-exposed newborns, especially if the mother smoked cigarettes in addition to using alcohol or drugs. Although as the child grows older, average weight frequently "catches up" to normal, low birth weight is a significant risk factor for developmental outcome as the child gets older.

Often accompanying poor weight gain is poor head growth, a reflection of poor brain growth in the womb. The average head circumference at birth is about 35 cm (13 inches). A head circumference below about 33 cm at birth is small and an indication of risk. Alcohol, cocaine, methamphetamines, and opiates have been shown to be closely associated with poor brain growth. In general, small head circumference at birth is a significant marker of risk for poor developmental outcome.

Prematurity

Women who use illicit drugs are more likely to smoke cigarettes, have infections complicating their pregnancy, and have inadequate prenatal care, all of which increase the likelihood of premature delivery (birth prior to 37 weeks gestation). In addition, cocaine and amphetamines have a direct effect on the uterus, causing contractions, while the woman's sudden cessation of opiate use (whether heroin, methadone, or prescription narcotic medication) also can cause uterine contractions. Thus, it is not surprising that there is a high rate of prematurity among prenatally exposed infants. Premature delivery robs the fetus of the opportunity to reach full growth potential in the womb and places the child at increased risk for medical and developmental problems in the long term. Educationally, prematurity may show its effects in learning and behavioral problems.

Congenital malformations

Children who have been prenatally exposed to substances of abuse may suffer a range of physical problems, often based on the direct toxic effect of the substance (such as alcohol) or the interruption of adequate blood flow to developing organs caused by substances such as cocaine or amphetamines. Alcohol can produce structural changes in the face and head, kidneys, heart, and other midline organs, while cocaine or methamphetamine use during pregnancy can result in a baby being born missing an arm, leg, or fingers. In addition, babies exposed to cocaine or methamphetamines prenatally have been reported to be missing a kidney or portion of the bowel due to infarction (death of the organ from lack of oxygen).

Changes in muscle tone

Muscle tone is the strength and tension present in a baby's muscles. Alcohol exposure is associated with weak or poor muscle tone in the infant. Cocaine, methamphetamines, phencyclidine (PCP, "angel dust"), and opiates such as heroin and methadone, as well as prescription narcotic medications, can produce tight, tremulous muscles in the exposed infant. This often is associated with arching behavior in which the infant arches his back when over-stimulated and draws up his arms and legs, clenches his fists, and curls his toes. The infant also can have difficulty with feeding if muscle tone is affected, frequently chewing on the nipple without being able to coordinate suck and swallow.

The Newborn Infant: What's Normal?

	AVERAGE	NORMAL
GESTATION (LENGTH OF PREGNANCY)	40 WEEKS	38 - 42 WEEKS
BIRTH WEIGHT AT TERM	7 LB. 8 OZ.	5 LB. 8 OZ. - 9 LB. 8 OZ.
BIRTH LENGTH AT TERM	20 INCHES	19" - 22"
BIRTH HEAD CIRCUMFERENCE	35 CM	33 CM - 38.5 CM
APGAR SCORES	7 OR ABOVE	7 - 10
DAILY FORMULA	17 OZ	15 - 20 OZ.
TOTAL DAILY SLEEP TIME	16 HOURS	
LONGEST SLEEP PERIOD	3-4 HOURS	

Infectious diseases

The use of drugs during pregnancy places the pregnant woman at high risk for a number of infections that can be passed to the fetus. From a broad perspective, any infection associated with blood borne transmission via dirty needles or any infection associated with exchange of body fluids, such as through sexual contact, occurs at increased frequency in substance abusing pregnant women. There are three major infections that must be considered prior to adoption.

Syphilis

Syphilis is a sexually transmitted disease that can cause severe structural and neurological complications in the infant of an untreated mother. State laws require that all pregnant women be tested for syphilis. In addition, hospitals test all women at the time of delivery. Therefore, in most instances, it is easy for prospective adoptive parents to learn whether a woman had syphilis during pregnancy. If her test for syphilis was negative or if it was positive and she received adequate treatment with penicillin, the baby will not be affected. However, an untreated case of syphilis during pregnancy can cause severe complications in the newborn's nervous system and bones. Any child born to a mother who was positive for syphilis but did not receive adequate treatment should himself be treated with a complete course of penicillin. This will protect the child and prevent any long-term complications.

HIV Infection

Acquired Immunodeficiency Syndrome (AIDS) is more prevalent among substance abusers than any other population. Passed through sharing needles as well as through sexual contact, every pregnant woman with a history of substance abuse should be tested for exposure to the Human Immunodeficiency Virus (HIV). If the woman is tested early in pregnancy and the test is negative, a repeat test is necessary in the third trimester if the woman has continued to use drugs or is sexually promiscuous. If a woman is negative for the HIV antibody in the third trimester, it is unlikely the child has been exposed to the AIDS virus and it is not necessary to test the infant, although some physicians and parents choose to do so.

In any child, if the baby's mother was positive for the HIV antibody, the newborn also will be positive. However, the positive test in the newborn may be due to the child's actual infection with HIV, or it may be due to the

passive passage of the mother's antibody across the placenta. There is no way of knowing the HIV positive newborn's status without conducting a PCR test or HIV culture on the baby. These tests are available for young infants through most major medical centers and can differentiate true infection from passive antibody.

Hepatitis

Two major forms of hepatitis, B and C, occur more commonly in the drug using population. All pregnant women are tested for Hepatitis B during prenatal care or at the time of delivery, and all newborns should receive the first of a series of three vaccines against Hepatitis B before leaving the newborn nursery. This series of vaccines will protect the baby against acquiring Hepatitis B, even if the mother were infected. So in a practical sense, Hepatitis B is not usually a problem for adoptive parents.

On the other hand, Hepatitis C is growing at epidemic rates in the United States, especially within the drug using population. Testing for Hepatitis C is not routine, but it is our strong recommendation that any newborn delivered to a woman with a history of substance abuse have a test for Hepatitis C prior to placement in a foster or adoptive home. If the baby is negative for Hepatitis C, there is no reason for further concern. However, if the baby is positive, he should have a PCR test to determine if he is truly infected (about a 5% chance) or if the positive antibody test is, as with AIDS, a result of passive transfer of the antibody from the mother. There is very little information about the long-term outcome of children born with Hepatitis C infection, but medical researchers are searching for treatment strategies.

Neurobehavioral changes

Newborn neurobehavior refers to the ability of infants to interact with their environment, to respond to stimuli as they occur, and to interact appropriately with the mother or other caregiver. Prenatal exposure to alcohol or drugs may interfere with these capabilities. Although physical difficulties in prenatally exposed infants occur in only about 25% to 30% of cases, neurobehavioral deficiencies are far more common and are at the basis of the difficulties a parent may have in caring for the child.

Motor behaviors

Drug-exposed infants may be quite stiff, with rigid posturing and hyperextension of the trunk. They may have difficulty reaching, grabbing, exploring objects, and bringing their hands to the midline; also, their reflexes may be hyperactive. On the other hand, quite a few of these infants, especially those who are alcohol-exposed, are very limp and lethargic at birth, with poor response to handling. In either case, the abnormal motor behavior interferes with coordination of the suck and swallow response, and feeding difficulties are not uncommon. Alcohol, cocaine, methamphetamine, PCP, and opiates have all been shown to affect motor behaviors of newborn infants.

Key areas of neurobehavior affected by prenatal drug exposure:

MOTOR BEHAVIOR

Reflexes, motor control, coordination of motor activities;

ORIENTATION

The infant's ability to respond to visual and auditory stimulation;

STATE CONTROL

The infant's ability to regulate his behavior by moving appropriately through the various states of arousal from sleep to awake to crying and irritable and to calm himself in response to the demands of the environment.

Orientation

Orientation capabilities suffer in newborns exposed to substances prenatally, affecting the newborn's ability to respond to sound and to visual stimuli. Although the infant hears the sound, she has difficulty finding where the sound came from or showing attention to the sound. Visual stimuli have the same effect, with the child's being able to perceive that there is something to see but having difficulty focusing her gaze, even briefly, on the object. Children prenatally exposed to most illicit drugs have varying degrees of difficulties with these orientation responses.

State Control

Substance-exposed infants often are unable to regulate their behavior. The infants frequently are very fragile, and their behavior changes tend to be abrupt and inappropriate with the child's moving from sleeping to crying for no particular reason. The newborn with neurobehavioral difficulties can become easily overloaded. Sudden change in light or sound levels can disrupt sleep. The infant demonstrates frequent startle and color change as she becomes over-stimulated. These rapid changes in state of responsiveness can confuse the parent and disrupt interactions between the infant and the parent. It is important to remember that the behaviors the infant is demonstrating are not a rejection of the parent but, rather, biologically based, and must be understood in this context.

CALMING STRATEGIES FOR THE NEWBORN INFANT

The best calming strategy for the newborn with neurobehavioral problems focuses on meeting the needs of the child and adjusting interactions based on what she can tolerate. The first signs of infant stress are sneezing, hiccupping, and yawning, followed by changes in skin color. When any of these occur, this usually is a signal that the baby is getting overloaded. The parent should step back, cease stimulating or interacting with the child, and give her some "cool down" time. A pacifier can help calm the infant. If the baby's behavior begins to escalate, swaddling her in a blanket will help her gain control.

Earliest signs of infant stress: Sneezing, Hiccupping, Yawning

Don't let your baby get over-upset and frantic.

Watch for early signs that the baby is getting upset: yawning, sneezing, hiccupping, jitteriness, skin color changes, refusing to look at you. When your baby sends out these distress signals, stop what you are doing and give him some time to recover.

Neonatal Abstinence Syndrome

If your baby keeps crying and isn't able to stop, quietly and gently soothe her.

Step 1: Wrap her snugly in a light blanket. When she begins to calm down, offer a pacifier. Sometimes a frantically crying baby will not be able to suck on a pacifier until she has calmed down a bit.

Step 2: Hold your baby wrapped in the blanket and rock back and forth. Be sure to hold the baby securely, one hand on the buttocks and the other on the back. Move the baby gently up and down. Sometimes it helps to have the baby face away from you.

Be careful to calm your baby in ways that he can tolerate.

Babies need stimulation. When the baby is awake and calm you can work on getting him to use your face and voice by smiling, making eye contact, and talking softly. But just use one kind of stimulation at a time. Be sure to watch for any signals that your baby is getting upset. Play with your baby when he is ready—not just when you want to.

As she gets used to you, increase the amount of stimulation you give your baby.

Talk, sing, smile, rock, or move your baby's arms and legs very gently. Her cues will tell you what she likes or doesn't like. When the baby is calm, unwrap her to allow her to move her arms and legs freely. Wrap her up again if she starts showing any signs of distress.

Neonatal Abstinence Syndrome

The use of heroin and other opiates has waxed and waned over the last several decades, but opiates once again are emerging as a major substance of abuse. No matter what form the opiate may take — whether it is heroin for intravenous injection, methadone used legally or illegally, or Vicodin® or Oxycotin® or other narcotic medications in the form of a prescription drug — the mother's use can result in the physical dependence of both the mother and the fetus. The newborn infant after birth goes through

Neurologic signs

STIFFNESS OF EXTREMITIES AND TRUNK
IRRITABILITY AND RESTLESSNESS
HIGH-PITCHED CRY
SLEEP DISTURBANCES
SEIZURES
TREMORS

Autonomic system dysfunction

YAWNING
NASAL STUFFINESS
SWEATING
SNEEZING
LOW-GRADE FEVER
FLUSHING AND PALE SKIN ACROSS BODY

Gastrointestinal abnormalities

DIARRHEA
VOMITING
POOR FEEDING
REGURGITATION
SWALLOWING PROBLEMS
POOR WEIGHT GAIN

Respiratory signs

RAPID BREATHING
PROLONGED PERIODS OF STOPPED BREATHING

Neurobehavioral abnormalities

IRRITABILITY
POOR RESPONSE TO AUDITORY/VISUAL STIMULATION

Miscellaneous

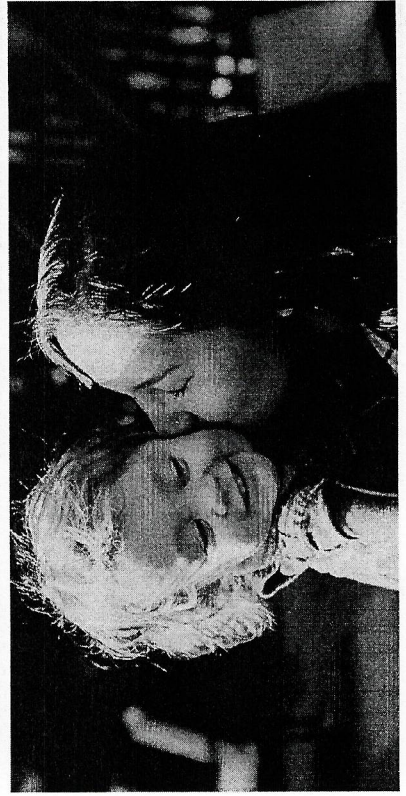
SCRATCHING OF THE SKIN

However, a drug-exposed infant often has difficulty with this and will keep moving his eyes back and forth to the red then blue block, unable to focus on the new stimulation offered by the blue block. This can be an early sign of regulatory difficulties.

By one year of age, many drug-exposed infants may become easily overloaded and cannot tolerate too much stimulation at once. For example, a one-year-old infant, if given a cube and a cup, will place the cube into the cup. When presented with eight cubes, a one-year-old typically can place multiple cubes into the cup. On the other hand, a one-year-old drug-exposed child, although able to put one cube into a cup if presented with one cube and a cup, will become agitated if presented with a cup and eight cubes at once. The infant frequently will begin to exhibit color changes, will break gaze with the caregiver, look around, become increasingly agitated, and then may scoop the cubes off the table.

In addition, it is not unusual for parents to note that their drug-exposed one-year-old child is highly distractible, always being the first member of the family to hear an airplane overhead or a bus driving by the outside window. These examples of easy overload and distractibility in young infants are important indicators of a regulatory problem, and parents must learn to provide stimulation slowly and in measured doses in order not to overload the child.

Continued distractibility can interfere with the child's play patterns as she gets older. Eighteen-month-old children who have been exposed



withdrawal, known as Neonatal Abstinence Syndrome, which mimics narcotic abstinence in an adult. The most significant features of the Neonatal Abstinence Syndrome are a high-pitched cry, sweating, tremulousness, scratching of the skin, vomiting, and diarrhea.

Symptoms of neonatal withdrawal from opiates may be present at birth but they might not appear until three to four days of life. However, withdrawal depends on many factors, and in some cases symptoms may not appear until ten to fourteen days after birth. The withdrawal symptoms peak around six weeks of age and can persist for four to six months or longer. The infants also may demonstrate many of the same problems as other prenatally exposed infants, including low birth weight, prematurity, muscle tone changes, and infant behavioral problems.

When discussing opiate use during pregnancy, it is important to at least briefly mention methadone treatment for narcotic addiction. Methadone is a synthetic narcotic that is used to treat individuals, including pregnant women, who are addicted to heroin, opium, or other narcotics. The advantage of methadone treatment is that it usually requires only one oral dose each day to suppress the desire to use heroin. The risk of infection with the Human Immunodeficiency Virus (HIV) that causes AIDS or with forms of Hepatitis is reduced when the pregnant woman is on methadone rather than continuing to use heroin or other narcotics. However, it is important to be aware that infants whose mothers are on methadone during pregnancy can undergo the same difficulties as infants whose mothers continue to use heroin throughout the pregnancy, especially if the mother is on more than 40 milligrams per day in the third trimester.

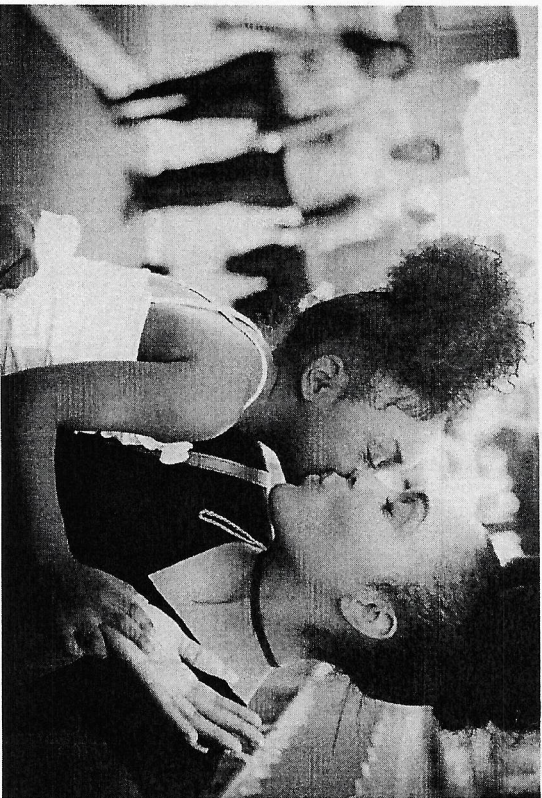
The Infant and Toddler

Behavioral regulation is the way in which a child interacts with his environment and responds to stimulation coming from the world around him, but prenatally exposed infants may demonstrate early signs of difficulty in controlling these responses. For example, three-month-old infants who have been prenatally exposed to illicit drugs can have problems regulating their levels of arousal and attention. As a component of this difficulty, the children are unable to screen out negative stimuli and are easily distracted by them. For example, in usual circumstances if you first put a red block and then a blue block in front of a six-month-old baby, the infant will be able to move his attention from the red block to the blue block.

in the womb to drugs may show striking deficits in a free play situation. They will have less representational play than normal and may demonstrate a high rate of scattering, bating, and picking up and putting down toys rather than sustained combining of toys, fantasy play, or curious exploration. Parents of drug-exposed infants often report that it is difficult to get the child to sit on the parent's lap and look at a book, because other objects or activities in the room easily distract the child. Distractibility and difficulty focusing on a task become more evident as the child begins to walk and play independently. The child appears more active and more random in his play patterns as he becomes more and more easily frustrated by unstructured situations.

The School-age Child

In studies of drug- and alcohol-exposed children who stay with their biologic mothers, the most important factor predicting the child's IQ at school age is the mother's drug use patterns in the six years after the child's birth. A home in which drugs are used is a home in which the child's needs for stimulation and developmental support are not met. These are the children most frequently presented in the media, and this perception of all drug-exposed children has permeated society's thinking about drug-exposed children. However, a stable and nurturing envi-



ronment as provided through a foster or adoptive home can change this outcome, and prenatally exposed children in adoptive homes often fare much better, with IQs that are significantly higher than the IQs of children who stayed with their biologic mothers who continue to use drugs.

On the other hand, many children prenatally exposed to drugs and alcohol, even if they have been adopted, by six years of age may demonstrate consistent behavioral difficulties: higher levels of anxiety and depression, problems paying attention, impulsive behavior, and distractibility. Prenatally exposed children with high levels of anxiety are easily frustrated when presented with challenging situations, feel others are out to get them, and can feel unloved, worthless, or inferior. The newborn infant who averted his gaze and withdrew into a deep sleep when over stimulated may become the little boy who daydreams, doesn't finish his assignments, is reluctant to participate in group activities, and does not have many friends. These children often are insecure and question their own capabilities, blaming themselves for their shortcomings.

Prenatally exposed children exhibiting impulsive and aggressive patterns of behavior often are characterized as "hyperactive." However, rather than hyperactivity, this could reflect the children's low threshold for stimulation and difficulty regulating themselves, especially when frustrated. The baby girl who could not easily move from a crying state to a calm interactive state can be seen as the preschooler who cannot calm down after recess or becomes argumentative and oppositional when she can't do what she

The picture of the drug- or alcohol-exposed child that emerges from research is one in which the child

- IS POORLY ORGANIZED;
- HAS TROUBLE REGULATING HIS BEHAVIOR;
- HAS TROUBLE STAYING ON TRACK AND COMPLETING A TASK;
- HAS HIGHER ACTIVITY LEVELS, HAS LOW FRUSTRATION LEVELS;
- POOR TOLERANCE FOR STIMULATION (I.E., EASILY OVER-STIMULATED);
- EXPERIENCES MORE ANXIETY AND DEPRESSION.

wants. The range and severity of behavioral difficulties is, of course, wide, and there simply is no way to identify the child who was prenatally exposed to alcohol or drugs merely on the basis of behavior. However, several studies indicate a significant relationship between prenatal substance exposure and behavior. Thus, we must be sure to view the exposed child as he should be viewed, not as willfully disobedient, but as a child whose neurological system may have been affected by the substances that crossed the placenta during pregnancy.

CAN I MAKE A DIFFERENCE IN THE LIFE OF A DRUG- OR ALCOHOL-EXPOSED CHILD?

The healthy infant is born with sound developmental capabilities that are enhanced by life circumstances. However, a baby whose mother used alcohol or drugs during pregnancy is vulnerable to a variety of risk factors that can negatively affect long-term outcome. As the number of risk factors builds, the risk for the child's ultimate outcome increases significantly. Nurturing and good parenting can modify the child's level of risk, building a level of resiliency that can protect the child and help him adapt to stressful events.

This concept of the balance of risk and resiliency guides our understanding of the role the adoptive family plays in enhancing the child's outcome. From research with adoptive families, it is clear that the way the family functions is an extremely important factor in affecting how the child ultimately develops. Adoptive parents can bring stability and love to a child that desperately needs such support. And this can make a tremendous difference in the child's long-term health, behavior, and achievement.

So, the question prospective foster and adoptive parents most frequently want answered is "Should we bring this child into our home?" Our reply frequently is yes, definitely yes in many cases. But once you bring the child into your family, early intervention is essential to facilitate your child's developmental progress. And it does not stop at early intervention.



Many of the children will face life-long challenges, and the parents must be sensitive to the needs of their maturing children as they enter progressively demanding environments and encounter growing societal expectations.

While some children do make remarkable progress once they are in a nurturing environment that provides appropriate stimulation and opportunities for learning, many children will need additional intervention in order to remediate delays. The neurological, prenatal and environmental risk factors that may contribute to their difficulties often warrant assistance from the Early Intervention System, Early Childhood Special Education programs, school programs, and private specialists and therapists. Given the risk factors faced by some children, it is important that intervention be sought whenever there are concerns, prior to the emergence of more serious problems with emotions, behavior or development.

Early intervention programs also can serve as a support system for parents, helping them to adjust to and accept the reality that their child is following a developmental trajectory that may or may not resemble that of "typical" children. Without this support, it is easy for parents to become overwhelmed and as a result feel inadequate or, worse, letting their disappointment and frustration affect the relationship with their new child.

Fostering or adopting a child affected by prenatal drug or alcohol exposure and helping him to reach his full potential may take some extra work and time on your part, but the rewards for you and your family often will far outweigh any difficulties you may face down the road. —

IN SUMMARY, OUR BEST ADVICE IS TO:

- RECOGNIZE THAT THE YOUNG INFANT NEEDS HELP IN RESPONDING TO STIMULI AND CAN GET EASILY OVERLOADED. PROVIDE INPUT BASED ON THE CHILD'S NEEDS AND LEARN TO READ HIS CUES. YOU CAN'T SPOIL A BABY, SO GO TO HIM WHEN HE CRIES AND PROVIDE THE COMFORT AND STRUCTURE THAT WILL HELP SOOTHE HIM.
- SEEK EARLY EVALUATION AND INTERVENTION SERVICES FOR YOUR CHILD. THE BEST WAY TO AVOID LONG-TERM PROBLEMS IS TO RECOGNIZE YOUR CHILD'S DIFFICULTIES AS SOON AS THEY EMERGE AND TO MOVE QUICKLY TO ADDRESS THEM.
- ORGANIZE AND STRUCTURE YOUR TODDLER'S ENVIRONMENT. HELP HER TO APPROACH TASKS IN AN ORGANIZED WAY, TAKING THINGS ONE STEP AT A TIME.
- REMEMBER THAT THERE IS A REASON FOR EVERY CHILD'S BEHAVIOR, AND IT IS IMPORTANT TO LOOK BEYOND THE SUPERFICIAL BEHAVIORS AND LEARN TO UNDERSTAND THE CHILD'S TOLERANCE FOR FRUSTRATION AND HER NEED FOR GUIDANCE DURING DIFFICULT TIMES, ESPECIALLY AS YOU MOVE FROM ONE ACTIVITY TO ANOTHER.
- HELP YOUR CHILD APPROACH SCHOOLWORK IN A CALM AND ORDERLY PROCESS. REALIZE THAT SOME TASKS MAY TAKE LONGER THAN EXPECTED BUT WITH SUPPORT AND ENCOURAGEMENT, YOUR CHILD WILL SUCCEED.
- WORK CLOSELY WITH THE SCHOOL TO PROVIDE FOR ANY SPECIAL NEEDS YOUR CHILD MAY HAVE.

