



Special Olympics

Motor Activities Training Program

Coaches Guide

Section VI: Appendices



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Appendix A – Glossary

Athletes with Severe Disabilities: are those who do not have the prerequisite skills to successfully compete in Special Olympics lower ability events.

Functional Ability refers to the amount of flexibility and/or strength the athlete has to perform desired movements, as well as their ability to understand what they are asked to do..

Independent: athlete completes the movement or task without assistance from the coach.

MOTOR ACTIVITY TRAINING PROGRAM *is a sport-based program designed for athletes with severe or profound intellectual disability who are unable to participate in Official Special Olympics sport competitions because of their skill and/or functional abilities. This does not refer to regular physical therapy that an individual receives for stimulation or rehabilitation purposes.*

Multidisciplinary Team: a diagnostic team selected on the basis of the individual's suspected problem. The team may include doctors, psychologists, social workers, teachers, physical therapists, speech therapists, nurses and other personnel.

Partial Assistance: the coach may touch, guide or direct the athlete, but not support or assist the athlete with the entire movement.

Peer Coaches: a peer coach is an individual of similar age to the athlete who, under the supervision of an MOTOR ACTIVITY TRAINING PROGRAM coach, assists with the athlete's eight-week training program.

Tactile Cues: Touching or physically moving a body part before, during or after the individual moves. These cues are designed to influence the occurrence of a behavior.

Total Assistance: the coach supports or assists the athlete with the entire movement.

Verbal Cues: verbal direction before, during or after the individual moves, designed to influence the occurrence of a behavior..

Visual Cues: visual signals or conditions occurring before, during or after the individual moves. Designed to influence the occurrence of a behavior..



APPENDIX B - References

Books - Journal Articles

Auxter D., Pyfer J., and C. Huettig. 2005. *Principles and methods of adapted physical education and recreation*. St. Louis: Mosby.

Block, M.E., Conatser, P., Montgomery, R., Flynn, L., Munson, D., & Dease, R. (2001). Effects of peer tutoring on the motor and affective behaviors of students with severe disabilities. *Palaestra*, 17(4), 34-39.

Block, M.E. (1992). What is appropriate physical education for students with the most profound disabilities? *Adapted Physical Activity Quarterly*, 9, 197-213.

Block, M.E., & Block, V.E. (1999). Functional v. developmental motor assessment for children with severe disabilities. In P. Jansma (Ed.), *The psychomotor domain and the seriously handicapped* (4th. ed.) (pp. 89-100). Lanham, MD: University Press of America.

Bowe, F. 1995. Birth to five: *Early childhood special education*. New York: Delmar.

Bredenkamp S. 1992. *Developmentally appropriate practice in early childhood programs serving children from birth through 8*. Washington, DC: National Association for the Education of Young Children.

Cowden, J., and C. Torrey. 1995. *A ROADMAP for assessing infants, toddlers, and preschoolers: the role of the adapted motor developmentalist*. *Adapted Physical Activity Quarterly* 12:1-11

Dummer., Et al. 1987. *Attributes of athletes with cerebral palsy*. *Adapted Physical Activity Quarterly* 4:278-292, 1987.

Fraser, B, Hensinger., R., and J. Phelps. 1987. *Physical Management of multiple handicaps*: Baltimore: Paul H. Brookes Publishing Company.

Gallahue, D.L. & Ozum, J. (1998). *Understanding Motor Development: Infants, Children, Adolescents, Adults*. Boston: McGraw-Hill.

Haley S. 1986. *Postural reactions in infants with Down Syndrome: relationship to motor milestone development and age*. *J AM Phys Ther* 66:17-22

Myall J., and G. Desharnair. 1995. *Positioning in a wheelchair, a guide for professional caregivers of the disabled adult*. Thorofare, NJ. Slack.

Meisels S., and S. Provence. 1989. *Screening and assessment: guidelines for identifying young disabled and developmentally vulnerable children and their families*. Washington DC: National Center for Clinical Infant Programs.



Payne, V., and L. acs. 1995. *Human motor development: A lifespan approach*. Mountain View, CA: Mayfield.

Sherrill, C. 2005. *Adapted physical activity, recreation and sport: Cross disciplinary and lifespan*. Madison, WI: McGraw-Hill.

Piper M., and J. Darrah. 1994. *Motor assessment of the developing infant*. Philadelphia: WB Saunders.

Ruoti, R., Morris, D., and A. Cole. 1996. *Aquatics rehabilitation*. Baltimore: Lippicott, Williams and Wilkins.

Schlein., S, and M. Ray. 1988. *Community recreation and persons with disabilities*. Baltimore: Paul H. Brookes Publishing Company.

Tecklin, J. 1998. *Pediatric physical therapy*. Baltimore: Lippicott, Williams and Wilkins.

Trombly, C., and M. Radomski. 2001. *Occupational Therapy for physical dysfunction*. Baltimore: Williams and Wilkins.

Winnick, J. (Ed) (2000), *Adapted Physical Education and Sport*. Champaign, IL: Human Kinetics.

Woollacott, M. 2000. *Motor control - theory and practical applications*. Baltimore: Lippicott, Williams and Wilkins.



Organizations

American Alliance for Health, Physical Education, Recreation and Dance, 1990 Association Drive, Reston, VA 22091.
<http://www.aahperd.org/>

American Foundation for the Blind, Inc., 15 West 16th Street, New York, NJ 10011. <http://www.afb.org/>

Association for Persons with Severe Handicaps, 7010 Roosevelt Way, N>E>, Seattle, WA 98115. www.tash.org

Epilepsy Foundation of America, 4351 Garden City Drive, Suite 406, Landover, MD 20785.

<http://www.epilepsyfoundation.org/>

Council for Exceptional Children, 1920 Association Drive, Reston, VA 22091. <http://www.cec.sped.org/>

Information Center for Individuals with Disabilities, 20 Providence St., Room 329, Boston, MA 02116

National Down Syndrome Society, 141 5th Avenue, New York, NY 10010. <http://www.ndss.org/>

National Easter Seal Society, 2023 W. Ogden Avenue, Chicago, IL 60612. <http://www.easterseals.com/>

National Head Injury Foundation, 280 Singletary Lane, Framingham, MA 01701. <http://www.headinjury.com/>

National Paraplegia Foundation, 333 North Michigan Avenue, Chicago, IL 60601 <http://www.sp-foundation.org/>

National Spinal Cord Injury Foundation, 369 Elliot Street, Newton Upper Falls, MA 02164. <http://www.spinalcord.org/>

National Wheelchair Athletic Association, 2107 Templeton Gap Rd., Suite C, Colorado Springs, CO 80907.
<http://www.wsusa.org/wsusa/>

Special Olympics, Inc., 1325 G Street, NW, Suite 500, Washington, DC 20005. www.specialolympics.org

United Cerebral Palsy Association, 66 E. 34th Street, New York, NY 10016 <http://www.ucp.org/>

United States Association for Blind Athletes, 55 West California Ave., Beach Haven Park, NJ 08008.
<http://www.usaba.org/>



Appendix C - HEALTH AND SAFETY CONCERNS

MOVEMENTS THAT INTERFERE WITH ATHLETE PERFORMANCE

Some MOTOR ACTIVITY TRAINING PROGRAM athletes may have very limited motor skill development. We are all born with approximately 100 reflexes including primitive reflexes, which are involuntary responses to stimuli. Stimuli for a reflex can include the position in which the athlete is placed, bending or turning of the head, a touch or a noise. At this early stage of development, athletes will have little control over their posture and a limited amount of voluntary control of movement. Further motor development depends upon the existence of these reflexes and the athlete's increasing ability to control them. Failure to lose or integrate these reflexes into a higher level of motor skill development interferes with more advanced movements. When a MOTOR ACTIVITY TRAINING PROGRAM athlete remains at the early primitive stage of motor development, his/her athletic performance will be affected.

In order to plan appropriate activities for MOTOR ACTIVITY TRAINING PROGRAM athletes, Certified MOTOR ACTIVITY TRAINING PROGRAM coaches must have knowledge of the movements that interfere with an athlete's performance. Some of these movements create problems during the performance of sport activities while others prevent an athlete from doing a sport skill without assistance. Athletes may have a limited ability to rotate or move their trunk, poor balance or poor head control. Others may start a movement for a sport skill and have some part of the movement, a noise or other stimulus in the room trigger an abrupt movement of part of the body or the whole body. This causes unwanted, uncontrolled movements that can jeopardize the safety or positioning of the athlete. Along with severe or profound intellectual disability, some MOTOR ACTIVITY TRAINING PROGRAM athletes may have signs of damage to their central nervous system including:

- Altered muscular tone
- Poor head control
- Retention of primitive reflexes and reactions
- Limited ability to rotate or move their trunk
- Involuntary movements
- Altered gait
- Poor balance
- Lack or altered awareness of their body parts

MOTOR ACTIVITY TRAINING PROGRAM coaches must have knowledge of the differences in muscle tone and reflexes and reactions in order to prevent serious injuries to the athletes and to help them perform as many sport activities as possible. In order to obtain this information, coaches should consult with parents, caregivers, adapted physical educators, physical therapists, occupational therapists, and/or nurses. The following muscle tones, reflexes and reactions are included in the MOTOR ACTIVITY TRAINING PROGRAM Coach Training Program.

Muscle Tone

Muscle tone, the tension (stiffness) in a muscle, is controlled by the central nervous system. Muscle tone is used to maintain posture and provide coordination for movement and activities in general. Although muscle tone is controlled



by the central nervous system, individuals may voluntarily change the tension of a muscle (i.e. flex a muscle). Abnormal muscle tone may affect an athlete's strength, flexibility, agility, fitness, endurance, cardiovascular ability and overall performance of a sport skill.

There are three types of muscle tone created by problems of the central nervous system that may influence the movement of an MOTOR ACTIVITY TRAINING PROGRAM athlete. They are hypotonic, hypertonic and fluctuating muscle tone. Hypotonic muscle tone is a condition in which there is too little or no tension in the muscle. These athletes are said to have low muscle tone. Many of the athletes with Down syndrome have very flexible joints (floppy joints) because the muscles surrounding the joints are hypotonic. Hypertonic muscle tone is a condition in which there is too much tension in the muscle or muscle groups. This interferes with the athlete's ability to move the limbs or joints controlled by the hypertonic muscles. Fluctuating muscle tone is a condition in which an athlete may have muscles that shift back and forth between too little and too much muscle tone.

Palmar Grasp

The Palmar Grasp is a reflex that causes an individual to grasp an object placed in the palm of his/her hand. Athletes who are functioning at the first developmental stage should be able to grasp a finger or object placed in the palm of their hands. If they have progressed to the second developmental stage, they can grasp a ball and release it to pick up another object or ball. Many athletes may be able to grasp a ball or racquet but cannot release it because of the reflex (perseveration of the reflex). It may take a lot of patience on the part of the coach and a considerable amount of time for the athlete to learn to release the object.

Startle Reflex

The startle reflex causes the athlete to suddenly arch the back and extend the arms and legs. The stimulus for the startle reflex can be a loud noise, a sudden movement of the athlete's head, a bright light or even a touch on the abdomen. After the initial reflex occurs, the athlete will relax and assume his/her original position. It is important for a coach and/or peer coach to know which athletes retain the startle reflex. An athlete who has the startle reflex and is left unattended or improperly secured in his/her chair may sustain severe injury.

Response to Gravity

Responses to gravity are triggered when you place an athlete on his/her back or stomach. Gravity acts on the head and pulls the athlete toward the support surface (floor). These responses to gravity are designed to help individuals develop the ability to voluntarily move limbs, and maintain posture and balance. Movements include straightening the arms and legs, folding them into the body and lifting them against the pull of gravity. The following reflexes and reactions can interfere with an athlete's performance.

Tonic Labyrinthine Prone Reflex (TLP)

The Tonic Labyrinthine Prone Reflex occurs when the athlete is placed on the stomach. The athlete's limbs and head will be involuntarily pulled toward the support surface in a flexed position. In this case the head bends toward the chest while the hips, knees, elbows and shoulders bend or fold toward the surface or under the athlete's stomach. The reflex may be so strong that the hips are raised off the floor. The Tonic Labyrinthine Prone Reflex is more obvious when you place an athlete on a scooter board and the limbs and head bend toward the floor.

Tonic Labyrinthine Supine Reflex (TLS)

When an athlete who retains the Tonic Labyrinthine Supine Reflex is placed on his/her back, the response to gravity causes the head and limbs to extend. The back of the head presses into the floor and the arms and legs are also pulled



toward the floor/support surface. In extreme cases, the back may arch so much that the trunk lifts off the floor leaving the athlete's weight resting on the shoulders and hips.

Some MOTOR ACTIVITY TRAINING PROGRAM athletes may continue to demonstrate the TLP and TLS reflexes. When these two reflexes are present, athletes will have difficulty lifting the head or any limb against the force of gravity. They do not have the muscular strength to overcome the force of gravity, which is pulling them toward the ground. Placing these athletes on their backs and asking them to lift their head or raise an arm to hit a ball creates a situation in which they will often fail. Coaches should observe them carefully since they will become fatigued in a short time and have trouble sitting up or standing for any length of time. If they are sitting in a chair trying to hit a ball, they may slowly give into gravity and slide out of the chair or rest heavily on the support surface/table/tray.

Asymmetrical Tonic Neck Reflex (ATNR)

The Asymmetrical Tonic Neck Reflex occurs when the head is turned to the right or left. When the athlete's face is turned toward the right side of his/her body, the right arm and leg extend and the left arm and leg flex. This position is similar to a fencer's position. If the athlete's head is turned to the left, the opposite occurs. The arm and leg on the left side extend while the arm and leg on the right side flex.

When the Asymmetrical Tonic Neck Reflex is retained, athletes are unable to do certain movements. If an athlete attempts to throw a ball and turns his/her head to look at the ball, the arm on that side will extend. Since the arm is straight, the only way he/she can throw the ball from that position is to move the whole arm forward from the shoulder. Athletes could also avoid looking at the throwing arm, which would allow them to bend (flex) the arm and throw the ball. Retaining this reflex also interferes with the ability of athletes when they walk. Looking toward one side of the body may cause the opposite leg to collapse and the athlete to fall.

Athletes with the asymmetrical tonic neck reflex may also have trouble using the two hands or arms together. Turning their head toward one side or the other causes one arm to extend and the other arm to flex. Athletes who retain this reflex must have a ball or other piece of sport equipment placed at the midline of their body so that the head does not have to turn. If a ball or sport equipment is not placed near the middle of their body, the reflex will be triggered and they will be unable to perform the sport skill.

Symmetrical Tonic Neck Reflex (STNR)

The Symmetrical Tonic Neck Reflex occurs when the head (neck/chin) is bent forward or backward. The arms do the same movement as the head while the legs do the opposite movement. For example, when the athlete's head (chin) is bent toward the chest, the arms also flex while the legs extend. If you extend the athlete's neck, moving the head toward his/her back, the arms extend and the legs flex.

Athletes who still have this reflex will have trouble performing a variety of sport skills. For example, when an athlete attempts to putt a golf ball and bends his/her head down to look at the ball, the movement of the head triggers the symmetrical tonic neck reflex. This causes the athlete to not only flex the arms, which pulls the putter away from the ball but also causes the athlete to straighten his/her legs.

The Symmetrical Tonic Neck Reflex also interferes with walking. If an athlete is walking and looks up, the arms will extend and the legs will flex. This causes the legs to collapse, and the athlete to fall. The only way an athlete can walk is to keep the head in a neutral position without bending it down (forward) or backward. Activities for athletes demonstrating the Symmetrical Tonic Neck Reflex should be carefully selected in order to avoid putting the athlete in danger or interfering with the success of the athlete.



Positive Support Reflex

The stimulus for the Positive Support Reflex is contact of the ball of the foot with the ground or support surface. Athletes who have not integrated the Positive Support Reflex will lock their knees when the balls of their feet make contact with the floor or a hard surface. This rigidity or stiffness of the legs interferes with their ability to walk. Athletes who still retain the Positive Support Reflex have a tendency to walk on the balls of their feet and will not be able to put the heel down first in walking.

Retention of the Positive Support Reflex is also obvious when an athlete tries to sit down in a chair or rise out of a chair. If the ball of his/her foot hits the floor, the legs will extend forcefully (shoot out) and the athlete will fall into or out of the chair. Therefore, to get in and out of a chair, the athlete must put the whole foot or the heels down first. To do this, an athlete who is attempting to stand moves forward in the chair before placing his/her foot on the floor; while an athlete attempting to sit on a chair moves the hips back over the seat of the chair before sitting down.

Propping Reactions

The Propping Reactions, also called the Parachute or Protective Extension Reactions, are used to maintain balance. The first to appear is the Propping Reaction to the front. The athlete's hands are placed on the floor, in front of the body, with the palms down on the surface. At the first developmental stage, athletes will have the ability to maintain a balanced sitting position by placing their hands on the floor out to their sides. By the second developmental stage, they can sit by placing their hands on the floor in back of them.

Athletes who have only developed the ability to support themselves with the hands in front of their body should be watched carefully. If they take one hand off the floor to push a ball, it is highly possible that they will lose their balance and fall to the side or back. Coaches should be ready to provide additional support on each side and to the back of the athletes.



Health Issues

Athletes with severe or profound intellectual disability may have a number of health related problems. Common conditions include decreased heart function, poor blood circulation, asthma, an inability to tolerate extreme temperatures and severe allergic reactions. The following sections provide the MOTOR ACTIVITY TRAINING PROGRAM coach with information on some of the basic health concerns.

Pressure Sores

Pressure sores (decubitus ulcers) are an irritation or sore on the skin caused by constant pressure. These occur on the part of the body that constantly touches a surface such as a chair, wheelchair or bed. While a pressure sore is not caused by the sport activity, it can interfere with the athlete's ability to participate. Once pressure sores occur, they are difficult to control and can interrupt an athlete's training program. Treatment should be provided by the athlete's parents and trained medical personnel.

Medications

Coaches should be aware of the medications their athletes are taking, and what side effects are associated with those medications. A variety of medications prescribed for athletes with severe disabilities cause side effects that could disrupt an athlete's participation, such as drowsiness, double vision, balance problems and cramps. Some medications also increase the athlete's sensitivity to heat or sun exposure. Exposure to the sun, for even a short time, may cause an athlete to become sunburned or suffer from extreme dehydration, heat cramps, heat exhaustion or heat stroke.

Hydration

Hydration is a concern for all athletes but is a more complicated health issue for MOTOR ACTIVITY TRAINING PROGRAM athletes who cannot express a need for fluids. Dehydration can cause the athlete's body temperature to rise and may result in muscle cramps, heat exhaustion or heat stroke. Coaches should take steps to keep their athletes hydrated. Watch for athletes with excessive sweating, an indication of heat exhaustion, and for athletes who stop sweating or have hot but dry skin, an indication of heat stroke. These conditions require that the athlete be quickly removed from the sun, covered with cool towels, and replenished with fluids.

Seizures

Some MOTOR ACTIVITY TRAINING PROGRAM athletes may have seizure disorders. Coaches of athletes with seizure disorders should request information from parents/caregivers regarding specific care for their athlete during and after a seizure. While the cause of seizure disorders may not always be known, coaches must be aware of their athlete's condition, understand how the seizure will manifest itself, and protect the athlete during a seizure. There are several types of seizures but only petit mal and grand mal seizures (different terms may be used in different parts of world for these types of seizures) are discussed below.

Petit mal seizures occur suddenly and result in a loss of awareness for a few seconds up to a few minutes. The athlete usually has no warning and will not be aware that he/she has had a petit mal seizure. In most cases, the athlete will not fall down; he/she will continue standing or sitting in his/her chair.



Grand mal seizures are more serious. Athletes may experience warning signs of the seizure called an aura. The aura or warning signs can include a particular smell, an itching sensation or a visual disturbance. Grand mal seizures usually last a few minutes during which time the athlete will fall on the floor and experience jerking or thrashing movements of the body along with a loss of consciousness. Athletes who have grand mal seizures may wear a helmet since falling can cause head injury.

Protecting the athlete from injuring him/herself during a grand mal seizure is a serious concern. When possible, coaches should lower the athlete to the floor and then remove all furniture or potentially harmful objects away from the area. Once the seizure ends, coaches should allow the athlete to rest.

Involuntary Movements

Some athletes with severe or profound intellectual disability experience involuntary movements that can harm themselves or others. These movements range from mild muscle spasms to intense full body spasms. They can be in response to a loud unexpected noise, sudden bump or movement (startle reflex); or a muscle stretched beyond its normal range of motion or stretched too quickly (stretch reflex). An example of the stretch reflex can be seen if a coach assists an athlete with reaching for a ball beyond their normal range. In response, the athlete experiences a strong muscle contraction that pulls the arm back toward its original position. To prevent a stretch reflex, coaches are urged to help the athlete slowly move the limbs within the athlete's normal range of movement, hold the position for a few seconds, and then slowly return the limb to its original position. Also allowing the athlete to rest periodically helps to prevent unwanted muscle contractions that could interfere with the development of sport skills. Coaches should be careful not to confuse this response with angry or aggressive behaviors.



Mobility Devices

Motor Activity Training Program athletes who have severe or profound intellectual disability may need assistance from mobility devices such as gait trainers, canes, braces, walkers or wheelchairs. Since these athletes will be participating in the MOTOR ACTIVITY TRAINING PROGRAM, a coach needs to gain an understanding of the athlete's mobility devices. This includes learning about the function of the device and the way in which the device helps the athlete perform the sport skill. Coaches also should have a knowledge of the maintenance of mobility devices used in their program (i.e. brakes functioning properly, battery charged, etc.).



Transferring an Athlete

Transfer is a term used to describe moving the athlete from one place, a wheelchair or piece of furniture to another. The MOTOR ACTIVITY TRAINING PROGRAM coach is responsible for providing and/or supervising any assistance needed by an athlete participating in Motor Activity Training Program sessions or activities. In order to fulfill this responsibility, the coach must be aware of local training requirements for people serving in a personal assistant or transferring assistant role. These requirements vary by nation and locality. MOTOR ACTIVITY TRAINING PROGRAM athletes vary in the amount of strength and ability they have to move without assistance.

Things to Consider Prior to Transferring an Athlete

1. How much does the athlete weigh? How much does the coach weigh? A general guideline for lifting is one lifter for every 50 pounds (22 kg) of weight. Using this guideline, an athlete that weighs 100 pounds (45 kg) should be transferred by 2 coaches.
2. Does the athlete have a seizure disorder?
3. Does the athlete have joint deformities, joint dislocations, and/or muscle contractures?
4. Does the athlete have Harrington rods in his/her back to correct scoliosis?
5. Does the athlete exhibit abnormal reflex activity such as an extensor thrust or startle reflex?
6. Does the athlete have any ability to aid in the transfer?
7. How does the athlete prefer to deal with a transfer situation? Be sure to talk to the athlete when ever possible about preferences.

Some athletes may need or want to perform the sport activity from their wheelchairs while others may want to be moved to a chair or the floor. Athletes may also need assistance when transferring to and from their wheelchairs to a pool, car, or toilet. Coaches should consult with the athlete's parents, caregivers, physical therapist, occupational therapist and/or nurse to determine the safest way to transfer the athlete. The following tips, descriptions and illustrations cover the most common transfers needed by MOTOR ACTIVITY TRAINING PROGRAM athletes.

Transferring from Wheelchair to Floor

1. Face the athlete and explain what you are doing
2. Arrange all transfer equipment and furniture before starting the lift (chair, mat etc.)
3. Shorten the distance between the athlete and where he/she will be transferred
4. Lock the wheelchair brakes
5. Remove all moveable parts of the wheelchair that interfere with the transfer
6. Loosen all straps that secure the athlete to the chair
7. Allow the athlete to assist in the transfer
8. Use one or two coaches, as needed, to ensure the safety of both the athlete and coach
9. Choose one of the coaches to take control of the lift
10. Use a signal by the control coach, such as counting, to synchronize the lift
11. Prepare for the lift by having one coach stand next to the side of the wheelchair and slide both arms under the upper legs of the athlete (supporting the athlete near the hips)
12. Conclude with the other coach standing at the back of the wheelchair, reaching under the athlete's arms, grasping the forearms of the athlete and pressing the athlete's forearms against his/her trunk. The upper body of the athlete will rest on the arms of the coach, so it is critical that the coach has a firm grip on the athlete's forearms.

One Person Transfer from Floor

A one or two person transfer can be used to move the athlete from a mat to a wheelchair. As you lift the athlete, it is important that you do so by straightening your knees and hips while supporting the athlete close to your body. This way you can avoid unnecessary strain on your back. Follow the steps below to execute a two-person lift from the floor.



1. Explain to the athlete what you are going to do
2. Place the wheelchair close to the athlete and lock the brakes
3. Remove all moveable parts of wheelchair that interfere with the transfer
4. Squat next to the athlete's hips bending both the knees and hips of the athlete
5. Slide one arm under the upper legs (near the hips) of the athlete and the other arm around the back of the athlete's waist
6. Straighten your knees and hips, walk to the wheelchair and lower athlete into chair

Two Person Transfer from Wheelchair

1. Explain to the athlete what you are doing
2. Lock the wheelchair brakes
3. Remove all moveable parts of the wheelchair that interfere with transfer
4. Position a coach on each side of the athlete
5. Slide arms of one coach under the athlete's armpits and grasp the athlete's forearms in front of his/her body. The coach's forearms press the arms of the athlete against the athlete's trunk while the upper body of the athlete rests on the arms of the coach. It is critical for the coach to keep a firm grip on the athlete's forearms.
6. Slide both arms of the other coach under athlete's legs making a forearm lock close to the hips
7. Choose one of the coaches to take control of the lift
8. Synchronize the lift straightening the knees and hips simultaneously

Two Person Transfer into the Pool

1. Follow up with all transfer tips from wheelchair to mat (floor)
2. Assign coach one to support athlete's back and bring athlete to sitting position with legs in the pool
3. Position coach two in pool facing the athlete with both arms under the upper legs of the athlete (supporting athlete near the hips)
4. Squatting behind the athlete, coach one reaches under the athlete's arms and grasps the top of the athlete's forearms keeping the arms of the athlete pressed against his/her trunk. It is critical to retain a firm grip on the athlete's forearms.
5. Designate one coach to take control of the lift
6. Use a signal such as counting to synchronize the entrance into the pool
7. Support athlete with arms of coaches as athlete enters water

Two Person Transfer out of the Pool

1. Bring athlete close to the edge of the pool (use back float, walk, etc.) positioning the athlete with his/her back to the deck of the pool
2. Use coach one (who is not in the pool) to squat down at the edge of the pool, reach under the athlete's arms and grasp the top of the athlete's forearms. Keep the forearms against the athlete's trunk while resting the body of the athlete on the coaches' arms. Maintain a firm grip on the athlete's forearms.
3. Use coach two to face the athlete in the pool and place both arms under the upper legs of the athlete (support athlete near the hips)
4. Use one coach to take control of the lift
5. Decide on a signal such as counting to synchronize the exit out of the pool
6. Position athlete in sitting position with legs in pool

Please Note:

A variety of equipment may be used to assist with transfers including hoists, slings and ramps. Coaches should consult with the athlete's parents, caregivers, physical therapist, occupational therapist and/or nurse to determine the equipment the athlete uses regularly, and the appropriate way to use that equipment.



Appendix D – Sample Coaches Training Agenda



Special
Take It to the



Olympics Motor
Next Level



Activities School –



Where:

When:

Agenda:

8:30-9:00 AM		Registration (bagels, fruit, juice and coffee available)
9:00-9:45	I:	Introduction to MATP <ul style="list-style-type: none">• Program Emphasis• 7 Basic Activities• Program Philosophy
9:45-10:15	II:	Training Needs <ul style="list-style-type: none">• Techniques• Equipment• Assessment• Transferring & Positioning Review – Current Practices
10:15		Break
10:30-11:30	III:	Designing Activities <ul style="list-style-type: none">• Warm-Up and Stretching Activities• Sport-Related Motor Activities
11:30-12:15 PM		Lunch
12:15-12:50	IV:	Seeing MATP in Action – Demonstrations by XXXXXX School Students



12:50-2:00	V:	Putting Theory into Practice (Self-Selected Break in Middle) <ul style="list-style-type: none">• Small Group work (Designing MATP Activity in Subgroup and Demonstrating to Group)• Sharing Best Practices Among Group
2:00-2:45	VI:	Implementing the Program <ul style="list-style-type: none">• Becoming a Part of Special Olympics• Conducting a Challenge Day – How To/How To Improve• Involvement of Students as Partners/Coaches
2:45-3:00	VII:	Debrief Training; Evaluation and Certification

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