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| **School District Name Here** |

**SCOLIOSIS SCREENING PARENT/GUARDIAN NOTIFICATION OF RESULTS AND REFERRAL**

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_\_\_\_ Date: ­\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dear Parent/Guardian:

🞏 Your child was screened for scoliosis at school and no issues were noted.

🞏 Your child was screened for scoliosis at school as required by state law. Your child’s screening showed a possible spine problem.  It is important that you have your child’s medical provider check their spine.  Please bring this form with you to your appointment, and ask the provider to complete the bottom section.  Please return the completed form to school.  Feel free to contact us if you have questions.

**SCHOOL SCREENING FINDINGS:**  (**L**-left, **R**-right, **S**-standing, **B**-bent over)

 **L R S B S B**

🞏 🞏 🞏 🞏 Higher shoulder 🞏 🞏 Asymmetrical skin folds

🞏 🞏 🞏 🞏 Shoulder blade prominence 🞏 🞏 Exaggerated thoracic curve

🞏 🞏 🞏 🞏 Obvious curve of the spine 🞏 🞏 Exaggerated lumbar curve

🞏 🞏 🞏 🞏 Vertebrae appear to rotate to one side 🞏 🞏 Head not centered over midline

🞏 🞏 🞏 🞏 Rib prominence Scoliometer reading\_\_\_\_\_\_\_\_\_\_\_\_

🞏 🞏 🞏 🞏 Higher hip

🞏 🞏 🞏 🞏 Arm greater distance from body, or appears longer

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**School Health Professional:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL PROVIDER’S RECOMMENDATIONS AND ORDERS: (Attach additional pages as needed with signature/date)**

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recommendations:

🞏 Observation

🞏 Brace: Number of hours to be worn at school: \_\_\_\_\_

🞏 Student can remove brace at school: 🞏 Yes 🞏 No. If Yes: Length of time removed: \_\_\_\_\_\_\_\_\_\_\_

🞏 Physical Therapy

🞏 Surgery

🞏 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞏 Referral (please describe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Activity Limitations (if any, please describe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Provider**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Please print name) (Signature)

Phone: \_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_

**For school use:**

🞏 Completed form received on date: \_\_\_\_\_\_\_\_\_\_\_\_

🞏 Completed for not returned to school

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| Sample resource created by NYS Center for School Health located at [www.schoolhealthny.com](http://www.schoolhealthny.com) 5/2018 |
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