SCOLIOSIS SCREENING PARENT/GUARDIAN NOTIFICATION AND REFERRAL

Name: _____ DOB: ___/___/_____ Date: _____

Address: _____

School: _____ School Phone: _____

Dear Parent/Guardian:

Our school recently screened your child for scoliosis 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. If there is a problem, finding a spine problem early gives you more choices about how to treat it.

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 Screener's Name & Title:_____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:

This form completed & received by school (name/date):_____

This form not returned to school (reason):_____