H511.400 (8,00)

School District ______________________________

NAME OF CHILD ______________________ SEX ______ DATE ______________

ADDRESS ______________________ GRADE ______________

SCHOOL ______________________

Dear Parent/Guardian:

In a recent screening program your child displayed possible scoliosis, or curvature of the spine. Further evaluation is recommended to determine if treatment is necessary. The effect of scoliosis depends upon its severity, how early it is detected, and how promptly it is treated. Please have your child examined by your family physician or check with the school nurse for other sources of treatment.

Please have the examining physician complete the form on the back of this letter and return it to the school nurse.

If you have any questions, please telephone the school nurse.

______________________ ______________________

School Nurse Qualified Rescreener

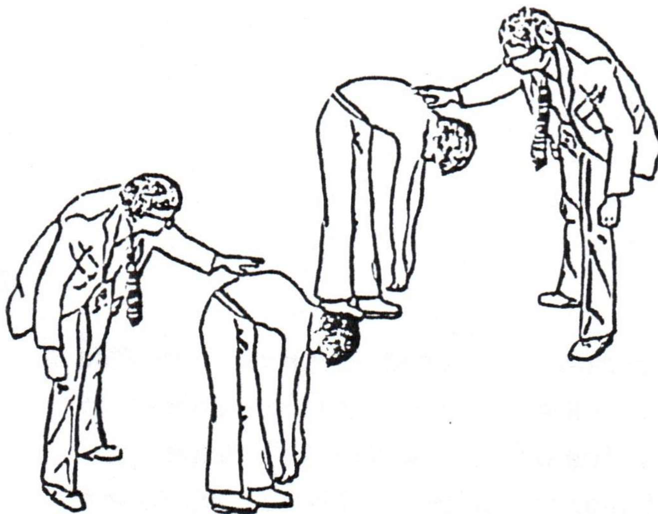
____

Telephone Number

Dear Physician:

Pennsylvania Department of Health regulations require each child in grades 6 and 7 and age appropriate (11 and 12 years of age) children in ungraded classes to be screened for scoliosis.

By using the method depicted below, a possible spinal curvature was noted on this student. Please note your findings on the checklist below.



OBSERVATIONS AT SCREENING

1. Rib/Hump Lumbar Rotation

   ____ Right Thoracic Rib Hump
   ____ Left Thoracic Rib Hump
   ____ Right Lumbar Rotation
   ____ Left Lumbar Rotation

2. Other Orthopedic Conditions

   ____ Pelvic Level
      ____ Right iliac crest higher
      ____ Left iliac crest higher
   ____ Kyphosis
   ____ Lordosis
   ____ Other

PHYSICIAN'S FINDINGS

EXAMINATION (Please check)

1. Scoliosis confirmed.............................. ☐
   * X-ray taken
   Degree of curve (specify) ____________
2. Possible scoliosis................................ ☐
   No X-ray taken
3. No scoliosis.. ☐
   X-ray taken
4. No scoliosis.. ☐
   No X-ray taken
5. Other orthopedic conditions................ ☐
   Confirmed

RECOMMENDATIONS (Please check)

1. Will observe.. ☐
2. Recommend bracing.......................... ☐
3. Recommend surgery........................... ☐
4. Discharged.. ☐
5. Comments ______________________

   ____

Signature ______________________

Physician (print) ______________________

Date ______________________

* *Single erect AP X-ray for baseline recommended by the American Academy of Orthopedic Surgeons.*