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 children (11 and 12 years of age) 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
   - _____ Lordosism

**PHYSICIAN’S FINDINGS**

<table>
<thead>
<tr>
<th>EXAMINATION</th>
<th>RECOMMENDATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Scoliosis confirmed…………………….☐</td>
<td>1. Will observe…………………….☐</td>
</tr>
<tr>
<td>* X-ray taken</td>
<td>2. Recommend bracing…………………….☐</td>
</tr>
<tr>
<td>Degree of curve (specify)__________</td>
<td>3. Recommend surgery…………………….☐</td>
</tr>
<tr>
<td>2. Possible scoliosis…………………….☐</td>
<td>4. Discharged…………………….☐</td>
</tr>
<tr>
<td>No X-ray taken</td>
<td>5. Comments __________________________</td>
</tr>
</tbody>
</table>
| 3. No scoliosis…………………….☐ | |_________________ _______________
| X-ray taken | Signature __________________________ |
| 4. No scoliosis…………………….☐ | Physician (print) ______________________ |
| No X-ray taken | Date ______________________________ |
| 5. Other orthopedic conditions………...☐ | |

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