

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

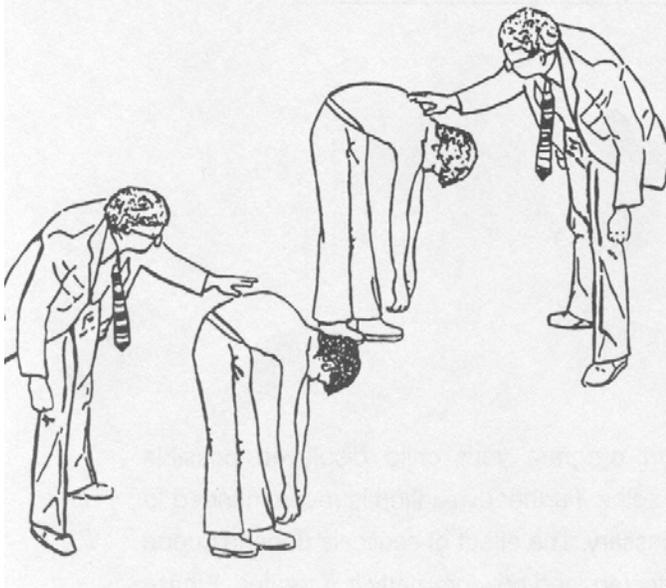
\_\_\_\_\_  
Qualified Rescreener

\_\_\_\_\_  
Telephone Number

Dear Physician:

Pennsylvania Department of Health regulations require each child in grades 6 and 7 and age- appropriate 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
  - \_\_\_\_\_ Lordosis

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**PHYSICIAN'S FINDINGS**

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**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.*