WARRIOR RUN SCHOOL DISTRICT

Dr. Alan J. Hack, Superintendent
4800 Susquehanna Trail
Turbotville, PA 17772
570-649-5138

Dear Parent/ Guardian(s) of 6th and 7th grade students:

According to the Pennsylvania School Code "a scoliosis screening test shall be administered to students in grade six and seven" (ages 11/12). Scoliosis, the most common spinal abnormality, is a side-to-side curve of the spine. The purpose of the screening is to detect signs of spinal curvature at their earliest stages. If the condition is detected early and appropriately treated, progressive spinal deformity may be prevented.

The screening test is very simple and can be performed in less than a minute. The procedure for screening is basic. Your child's back will be checked by observing it while she is bending forward. For this screening, boys and girls will be seen separately and individually. To assure a view of the spine we request that students expose their back during screening.

The school nurse or the physical therapist will conduct a scoliosis screening during the month of March. A physical therapist from ***The Children's Development Center*** in Williamsport will be scheduled to re-evaluate those few children who we feel may have a curvature. This service is provided to you at no cost. You will be notified if medical follow up is necessary.

Should you prefer your child's physician to perform the scoliosis screening, this is also acceptable. Please indicate your preference on the **consent form attached below** and return as soon as possible. If you have any questions please call the middle school nurse at (570) 649-5166, Ext 3008.

Sincerely,

Health Room Nurses

Elementary School
301 Pine Street
Turbotville PA, 17772
570-649-5164

Middle School
4860 Susquehanna Trail
Turbotville PA, 17772
570-649-5135

High School
4800 Susquehanna Trail
Turbotville PA, 17772
570-649-5166

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PERMISSION FORM

SCOLIOSIS SCREENING PROGRAM

Child's Name: _____ Grade/Age:_____

_____ I give permission for my child to be screened at school for scoliosis by a school nurse or Physical therapist.

_____ I do not give permission for a scoliosis check. I will have my child examined by our family doctor and return the form below.

_____ _____

Parent/Guardian Signature ***Date***

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PHYSICIAN'S FINDINGS

EXAMINATION (Please Check)

___Scoliosis Confirmed. X-ray taken
Degree of curve (specify)_____

___Possible scoliosis. No X-ray taken.

___No Scoliosis. X-ray taken.

___No Scoliosis. No X-ray taken.

___Other orthopedic conditions confirmed.

RECOMMENDATIONS (Please Check)

___ Will observe.

___Recommend bracing.

___Recommend surgery.

___Discharged.

Comments:_____
_____

Physician Signature_____

Physician (print)_____ Date: _____

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