GEORGIA DEPARTMENT OF PUBLIC HEALTH

Form #4400

Certificate of Scoliosis Screening

Required for students entering 6th **and** 8th grade

Form must be completed in its entirety and returned within 90 days of school start

Student name: _____
First Middle Last

Date of Birth: __/__/____ Gender: Male___ Female___ Grade: _____

Student Address: _____
Street City

_____
Zip code County State

Name of School: _____

Parent/Guardian Contact information:

Name: _____

Phone number: _____

Email: _____@_____

Scoliosis Screening (Adams Forward Bend Test) Results:

Negative screen: _____
Needs further evaluation: _____
Referred to provider: _____

Screener's Comments:

Screening completed by:
Physician Practice: _____ County Health Department: _____
Licensed School Nurse: _____

Screener Information:
Name: _____ Office Address: _____
Signature: _____ Date: __/__/____

Parent/Guardian – Complete This Portion Only if Student Will Not Be Screened

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Opt-out

_____**I do not want my student to be screened for scoliosis at this time.**

_____**The student listed above is currently under professional care for scoliosis.**

Parent/Guardian's Signature: _____Date: __/__/___
