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

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: _ _ / _ _ / _ _ _