MT. LEBANON SCHOOL DISTRICT
HEALTH SERVICES

PRIVATE PHYSICIAN SCOLIOSIS SCREENING

Scoliosis screening is mandated by the Pennsylvania Department of Health for 7th grade students. The purpose of this screening is to detect possible curvature of the spine. When the condition is detected early, and appropriately treated, progressive spinal deformity may be prevented. **If you choose to have this screening performed by your child's licensed Pennsylvania Healthcare Provider, please have this form completed and returned to your child's school nurse by December 1st. If this is not returned by that date, then the scoliosis screening will be performed by your child's Certified School Nurse.**

Student Name_____ Birth Date _____

School _____ Grade _____

SCOLIOSIS FINDINGS:

_____ **POSITIVE** _____ **NEGATIVE**

If positive, follow-up recommendations:

_____

_____

I understand and agree that medical information may be shared with appropriate personnel. I authorize my child's physician to release any medical information that may be required by district personnel.

_____ _____
Parent Signature **Date**

_____ _____
Physician Signature **Date**

_____ _____
Physician Stamp/Address **Physician Phone Number**

Please return this completed form to your child's school nursing office by December 1st of your child's school year.

7/25