Danville Area School District

Student Health Services

Danville Senior High School
St Joseph's Elementary
St Cyril´s Kindergarten
Carla Raup, MHA, BS, RN, CSN
570-271-3268 ext 1103
Fax # 866-240-4318

Danville Middle School
Homeschool
Abbie Blasick, BSN, RN, CSN
570-271-3268 ext 3804
Fax # 866-283-7030

Liberty Valley Intermediate
Abbie Blasick, BSN, RN, CSN
Ruth Hosterman, LPN
570-271-3268 ext 3414
Fax # 866-428-5112

Danville Primary School
Carla Raup, MHA, BS, RN, CSN
Jessica Petersen, LPN
570-271-3268 ext 2108
Fax # 866 -274- 6209

To Parent/Guardian:

The Pennsylvania Department of Health requires a scoliosis screening for students in sixth and seventh grades. You may have your own private physician do this screening and complete the attached form or your child will have the screening done in school.

Please return the completed form to the school nurse prior to September 1, 2026, or your child will be screened in school.

If you have any questions regarding the above mandated screening, please feel free to contact your school nurse.

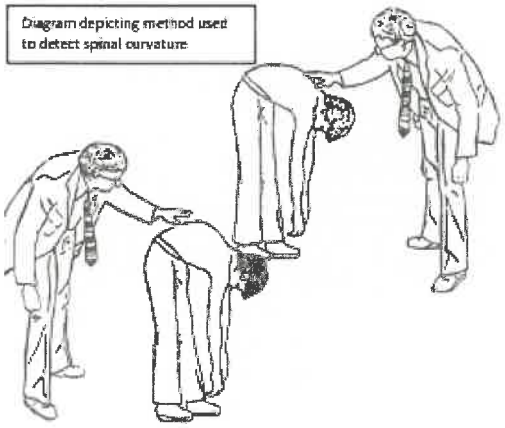
Sincerely,

Danville Area School Nurses

Letter to Physician and Physician Findings

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.


Diagram depicting method used to detect spinal curvature

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
   - _____ Other

PHYSICIAN'S FINDING

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: _____