

School Screening Log

Screening examiner: _____ Primary screening: ____ Secondary screening: ____

School: _____ Date of screening: _____

Grade: _____ Teacher: _____

Student's name	Negative	Referral	Male	Female	Birthdate	Follow-up
Totals						

Total not screened: _____

SCREENING FORM

Grade (circle): 6 7 8 Other: _____

Primary screening date: ____/____/____ Homeroom: _____

Student's last name: _____ First name: _____ M.I.: _____

Date of birth: ____/____/____ Race/ethnicity: _____ Female Male

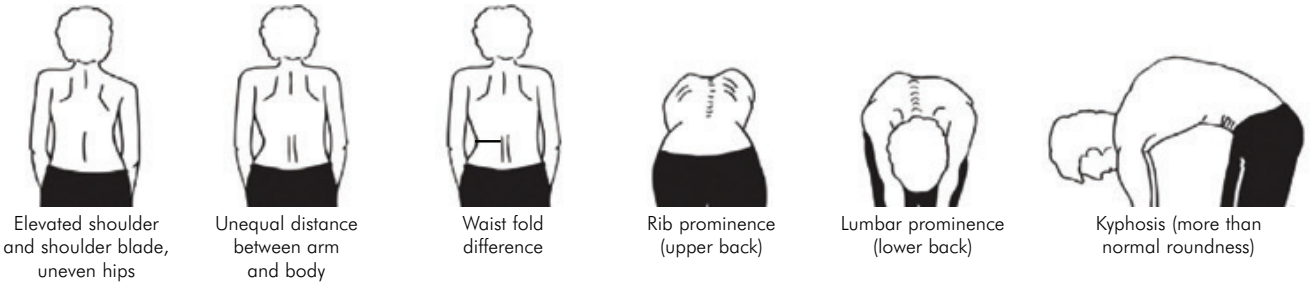
Name of parent/guardian: _____

Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Phones: Home (____) ____-____ Work (____) ____-____ Cell (____) ____-____

Name of school: _____ District: _____



	Primary screener		Secondary screener	
	Left	Right	Left	Right
Front				
Shoulder elevated				
Unequal distance arm to body				
Uneven hips				
Rib prominence				
Lumbar prominence				
Back				
Shoulder elevated				
Shoulder blade elevation/prominence				
Waist fold difference				
Unequal distance arm to body				
Rib prominence				
Lumbar prominence				
Side				
Kyphosis—more than normal roundness	Yes	No	Yes	No

Negative _____ Refer for second screening _____

Screener's name (print) _____

Check one: School nurse Teacher Volunteer

Clinic assistant Other: _____

Screener notes:

Secondary screening date: ____/____/____

Negative _____ Referred _____

Screener's name (print) _____

Check one: School nurse Health professional

Other: _____

Screener notes:

Date: _____

To the parent/guardian of: _____

Dear parent/guardian,

On _____, _____ conducted the annual state-mandated scoliosis screening for middle school students. A curve of the spine can appear during the years of rapid growth between ages 10 and 15. Findings of the screening indicate your child needs further examination. We recommend that you follow up with your child's primary care physician or provider for an evaluation. If your child does not have a doctor, you may contact the Children's Healthcare of Atlanta Scoliosis Screening Program at **404-255-1933**.

Children's offers a follow-up scoliosis screening that may include X-rays read by a pediatric radiologist. These screenings are offered at Children's locations throughout metro Atlanta. You may schedule an appointment or get additional information by visiting choa.org/scoliosis or calling **404-255-1933**.

Remember to take this letter with you to your child's provider or the provider at a Children's during your child's follow-up screening visit.

Complete the bottom portion of this form and return it to the school's clinic within 15 business days so that we can confirm your receipt of this notice, and note your plans for follow-up. **This information is not mandatory or required.**

Thank you for your cooperation.

(Signature of school nurse/public health nurse)

Date: _____

Return this section to your child's school clinic.

_____ I have received notification for recommendation for further examination of the positive findings of my child's scoliosis screening.

_____ I will contact my child's primary care physician or provider, or the Children's Healthcare of Atlanta's Scoliosis Screening Program to schedule an appointment.

_____ I have noted your correspondence but do not wish to provide any further information.

Student: _____ Grade: _____

Parent/guardian signature: _____ Date: _____

Fecha: _____

A los padres/tutor de _____

Estimado Padre / Tutor,

El _____, _____ llevó a cabo la evaluación anual de escoliosis ordenado por el estado para estudiantes de la escuela intermedia. Durante el período de crecimiento rápido, es decir entre los 10 y 15 años, puede aparecer una curvatura de la columna vertebral. Los resultados de la evaluación indican que su hijo necesita un examen más exhaustivo. Le recomendamos un seguimiento con el médico /proveedor de atención primaria de su hijo para una evaluación. Si su hijo no tiene un médico, puede comunicarse con el Programa de Detección de Escoliosis de Children's Healthcare of Atlanta al **404-255-1933**.

Children's Healthcare of Atlanta ofrece evaluaciones de seguimiento para la detección de la escoliosis que podrían incluir radiografías que son leídas por un radiólogo pediátrico. Estas evaluaciones se ofrecen en todas las ubicaciones de Children's of Healthcare of Atlanta en el área metropolitana de Atlanta. Puede programar una cita u obtener más información visitando **choa.org/scoliosis** o llamando al **404-255-1933**.

Usted debe llevar esta carta a la cita de seguimiento con el proveedor de su hijo o con el proveedor de Children's Healthcare de Atlanta.

Complete la parte inferior de este formulario y devuélvala a la clínica de la escuela dentro de 15 días hábiles, para que podamos confirmar su recibo de este aviso, y anote sus planes para el seguimiento. **Esta información no es obligatoria ni requerida.**

Agradecemos su cooperación

(Firma de la enfermera escolar/enfermera de salud pública)

Fecha: _____

Devolver esta parte a la clínica de la escuela de su hijo.

_____ He recibido la notificación que recomienda un examen más exhaustivo en vista de los hallazgos positivos de la evaluación de escoliosis de mi hijo.

_____ Me comunicaré con el proveedor primario de mi hijo o con el Programa de Detección de Escoliosis de Children's Healthcare of Atlanta's para programar una cita.

_____ He tomado nota de su correspondencia pero no deseo proporcionar más información.

Estudiante: _____ Grado: _____

Firma de uno de los padres/tutor: _____ Fecha: _____