

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 **404-785-7553**.

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 **404-785-7553**.

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: _____