HENRY COUNTY SCHOOLS

Scoliosis Screening Permission Letter

Dear Parent/ Guardian, Date_____

On _____, at _____Middle School, in cooperation with Henry County Health Department, we will conduct a screening program on our 6th and 8th grade students for Scoliosis (curvature of the spine). Scoliosis is most often seen in the middle school age group, when rapid growth is occurring. If this condition is detected early, follow-up is essential to determine treatment options to prevent possible spinal deformities.

The screening will be done by trained staff who will look at each child's back. No equipment is involved. You will **only** be notified if your child has suspected curvature and further evaluation by your child's physician, the health department, or Children's Healthcare of Atlanta will be requested.

The screening process is not embarrassing. The students will be asked to remove their shirts so their backs can be seen during the screening. The girls may wear swimsuit tops if preferred. The boys and girls are screened in separate groups and areas.

Sincerely,

Donna Culpepper LPN
Scoliosis Coordinator
770-288-6136

Parent or Guardian,
Please indicate on the form below if you **do, or do not** want your child to be screened. Then complete the information and **have your child return it to school.**

To the principal:

I DO want my child _____screened for scoliosis.

I DO NOT want my child _____to be screened for scoliosis.

PARENT SIGNATURE: _____

Form MUST BE RETURNED TO SCHOOL BY:_____

HENRY COUNTY SCHOOLS

Carta de Permiso de Escoliosis

Estimado Padre/Tutor, Fecha_____

En _____, en _____*Escuela*, en cooperacion con el Departamento de salud del Condado de Henry, llevamos a cabo un programa de examenes para alumnos de grado 6th y 8th para la escoliosis (Curvatura de la columna vertebral). Escoliosis se ve mas a menudo en el grupo de edad media-secundaria, cuando esta ocurriendo un crecimiento rapido. Si esta condicion se detecta temprano, seguimiento es esencial para determinar las opciones de tratamiento para evitar posibles deformidades espinales.

El examen se realizara por personal capacitado que examinara la espalda de cada niño. Ningun equipo se implicara. **Solo** se le notificara si su hijo/a es sospechado una curvatura y su hijo/a solicitara evaluacion de medico.

El proceso de seleccion no es vergonzoso. Los niños y niñas son evaluados en grupos separados. Las niñas piden usar tapas de traje de baño debajo de su ropa y los niños pueden quitar sus camisas para que la espalda se aprecia durante el examen.

Atentamente,
Donna Culpepper LPN
Coordinadora de Escoliosis
770-288-6136

Padres o Tutores,
Por Favor indique en el formulario de abajo si va a **hacer o no** quiere que su hijo/a haga el examen. Luego complete la informacion y **haga que su hijo/a lo devuelva a la escuela.**

Al Director:

Quiero que mi hijo/a _____ sea examinado/a para la escoliosis.

No Quiero que mi hijo/a _____sea examinado/a para la escoliosis.

FIRMA DE PADRE: _____

Formulario DEBE SER DEVUELTO A LA ESCUELA POR::_____

Scoliosis Screening Form

Primary Screening date: _____

Student's Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Race/Ethnicity: _____ Gender: Female _____ Male _____

Name of Parent/Guardian: _____

Address: _____ Apt. #: _____

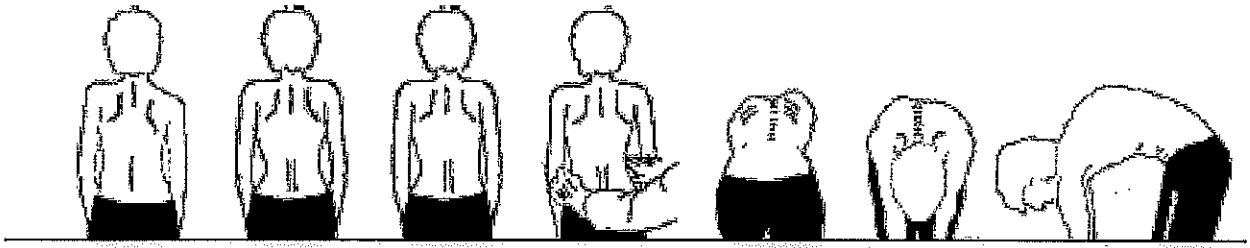
City: _____ State: _____ Zip code: _____

Phone (H): ____ /____ /____ Phone (W): ____ /____ /____

Additional contact information (i.e. cell phone #): ____ /____ /____

Name of School: _____ School District: _____

Grade level (circle one): 6 7 8 other _____



Elevated Shoulder | Shoulder blade (scapular) prominence | Unequal distance between arm and body | Uneven hips | Rib Prominence (Upper back) | Lumbar Prominence (Lower back) | More than normal roundness (kyphosis)

	Primary Screener Left	Primary Screener Right	Secondary Screener Left	Secondary Screener Right
Shoulder Elevated				
Shoulder Blade Prominence				
Unequal Distance Between Arm and Body				
Uneven Hips				
Rib Prominence				
Lumbar Prominence				
Kyphosis Increased				

Primary Screening

Date of screening: _____

Negative _____ Referred for 2° screening _____

Screener's name (print): _____

Check one: Volunteer ___ Teacher ___ Clinic Asst. ___

School Nurse ___ Other(Specify) ___

Health Dept. Employee ___

Comments of screener: _____

Secondary Screening

Date of screening: _____

Negative _____ Referred _____

Screener's name (print): _____

Check one: School Nurse ___

Health Dept. Employee ___

Other(Specify) _____

Comments of screener: _____