Dear Parents and Guardians:

The purpose of this letter is to inform you I will be performing spinal assessments in the school health office during the school year. I will notify you of findings only in cases where a referral is necessary. Students ages 10 to 18 are required by law to be evaluated for spinal curvature (possible scoliosis).

Boys and girls will be screened separately. Privacy is ensured. It is helpful when students wear a top that can be easily removed in order to allow assessment of the back.

Any student may be exempt from the examination upon the written request of the parent or guardian.

Please complete the bottom of this form and submit to the health office only if you would like your child to be excused from the screening.

Sincerely,
School Nurse

Please Do Not Detach

Student Name: ________________________________________________________________

Date: ____________________________ Grade____________________________

I DO NOT wish to have my child participate in the scoliosis screening program. Please indicate one of the following:

○ My child has been/will be screened by our private physician (please provide medical note from physician).

○ Other (please indicate): __________________________________________

Parent/Guardian Name (please print): __________________________________________

Parent/Guardian Signature: ___________________________________________________

**Please complete this form for each school year you would like your child to be exempt from scoliosis screening.