**Scoliosis Screening at School**

Dear Parent/Guardian:

This school year scoliosis (back) screening was **not** completed in the school district. You are encouraged to have your son/daughters’ primary physician or health care provider perform this brief exam of the back at their next annual appointment. Scoliosis is an abnormal lateral deviation in the spine. It may or may not include deformity or rotation of the vertebrae. Most cases (85%) have no known cause; Idiopathic Scoliosis results in a fixed rotation of the spine and is commonly observed and tested for in the school setting. It occurs more often in females than males. It usually develops during periods of active growth (10 to 16 years). Since this is **not a state** required screening we will **no longer be screening** for this at school. We can screen individually if requested.

If your child is currently being treated for scoliosis or you do not wish to have them participate, **please complete the section below and return it to me at the school.** This note must be returned to the office by September 1 for them to be screened at school.

If you have questions or comments, call ___________________ school and leave a message. I will return your call as soon as I can. Thank you for your cooperation.

Date:  _____________  ___________________________________________ R.N.

I **want** my child, ________________________________, in the 
(Name)  
___________ grade to participate in the scoliosis (back) exam.

Date:  _____________  ___________________________________________

My child is being followed/treated by Dr. ________________________________