Referral to Physician Form

Dear Parent/Guardian:

Your child was screened for spinal curvature on_____, and the results are:

( ) Obvious spinal curvature
( ) Shoulder elevation
( ) Should blades uneven
( ) Hips uneven
( ) Rib prominence
( ) Increased round back
( ) Spine hump

Other comments: _____

It is recommended that your child have a complete evaluation by your family physician.
Please take this form with you for your doctor to complete. **Please return the completed form to school.**

_____
School Nurse

_____ _____
Name of Student Birth Date

_____ _____ _____
School Grade Teacher's Name

Report from physician. Please complete and RETURN TO SCHOOL.

DIAGNOSIS: _____Scoliosis _____Kyphosis _____Other: (Specify) _____
TREATMENT: _____None _____Brace _____ Other: (Specify) _____
_____Observation _____Surgery

This form may be released to the school.

_____
Type or Print Name of Physician

_____ _____
Signature of Parent/Guardian Signature of Physician

_____ _____
Date Signed Date Signed

This form should be returned to the School Nurse, ATTN: Spinal Screening Program Administrator