

Stroudsburg Middle School
200 Pocono Commons, Stroudsburg, Pennsylvania 18360
Kathy Verbel M.S.,RN,C Certified School Nurse

Date: _____

Dear Parent/Guardian:

During the school year the Stroudsburg Area School District will conduct the State Mandated Seventh Grade Scoliosis Screening Program. The purpose of the screening is to detect possible curvature of the spine in children. If the condition is detected early and appropriately treated, progressive spinal deformity may be prevented.

The School Nurse will observe your child's back while the child is standing and bending forward. To assure a view of the spine, we will request that students expose their backs during the screening. This will be done in the privacy of the nurse's office. The screening will be done during your child's school day. You will be contacted if there is any reason to have your child examined by your doctor.

This is a state mandated screening therefore the exam must be completed either by the school or by your private physician. If the screening is NOT completed your child will be excluded from school on May 1st. until written proof of screening is received by the school.

Please indicate your intentions for this screening and return the permission slip immediately to the school nurse. Your child will not be screened until this permission form is returned.

If your child *is already being followed by their physician for scoliosis*, we request that an updated report from their private physician be forwarded to the school.

Sincerely,

Kathy Verbel M.S, RN, C, Certified School Nurse

PERMISSION SLIP FOR SCOLIOSIS SCREENING –RETURN IMMEDIATELY TO THE SCHOOL NURSE

Please print child's name, check desired response, and sign below.

_____ My child, _____, Homeroom No. _____ has PERMISSION to be screened for Scoliosis by the school nurse.

_____ I, the Parent/Guardian **WILL NOT** attend while my child is being screened.

_____ I, the Parent/Guardian will attend while my child is being screened. I will call for an appointment.

_____ My child, _____, **DOES NOT** have permission to be screened for Scoliosis **AND I will have my private physician screen my child.** I will provide the private physician's report. I realize that if I do not turn in the doctor's report my child may be excluded from school.

_____ My child, _____, **is already under a Doctor's care for Scoliosis and I will provide the physician's report.** I realize that if I do not turn in the doctor's report my child may be excluded from school.

Parent/Guardian Signature

Date

PHYSICIAN'S REPORT OF SCOLIOSIS: Child's Name _____

Findings: _____

Physician's Signature _____

Date _____

Revised: 8-08

Return to School Nurse