Scoliosis Screening

The Pennsylvania Department of Health requires a scoliosis screening for all students entering the seventh grade. Please have your child's physician complete this form and return it to the Campus School office on or before the first day of school. Thank you.

Physician's Findings

NAME OF STUDENT ____________________________________ DATE __________________

1. Rib Hump/Lumbar Rotation
   [ ] Right Thoracic Rib Hump (RT)
   [ ] Left Thoracic Rib Hump (LT)
   [ ] Right Lumbar Rotation (RT)
   [ ] Left Lumbar Rotation (LT)

2. Other Orthopedic Conditions
   [ ] Pelvic Level
      [ ] Right iliac crest higher (HR)
      [ ] Left iliac crest higher (LT)
   [ ] Kyphosis (K)
   [ ] Lordosis (L)
   [ ] Other __________________________

Examination (please check)

1. Scoliosis confirmed [ ]
   *X–ray taken
   Degree of curve (specify)
   ____

2. Possible scoliosis [ ]
   No x-ray taken

3. No scoliosis [ ]
   *X-ray taken

4. No Scoliosis [ ]
   No x-ray taken

Recommendations (Please Check)

1. Will observe [ ]
2. Recommend bracing [ ]
3. Recommend surgery [ ]
4. Discharged [ ]

5. Comments ________________
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** Single erect AP x-ray for baseline recommended by the American Academy of Orthopedic Surgeons.*

Physician's Signature ____

Physician (print name) ____

Date ________________________