Certificate of Scoliosis Screening

Scoliosis Screening is required for students in two grade levels determined by each school district.
This form must be completed in its entirety and returned to the child's school.
*This form is for use by providers when screening, **not** for mass screening events provided at school.*

Student name: _____
First Middle Last

Date of Birth: _ _/_ _/_ _ _ _ Gender: Male___ Female___ Grade: _____

Student Address: _____
Street City

_____
Zip code County State

Name of School: _____

Parent/Guardian Contact information:

Name: _____

Phone number: _____

Email: _____@_____

Scoliosis Screening (Adams Forward Bend Test) Results:

Negative screen: _____
Needs further evaluation: _____
Referred to provider: _____

Screener's Comments:

Screening completed by:
Physician Practice: _____ County Health Department: _____
Licensed School Nurse: _____

Screener Information:
Name: _____ Office Address: _____
Signature: _____ Date: _ _/ _ _/ _ _ _ _