Scoliosis Screening Form

Primary Screening date: _____

Student's Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Race/Ethnicity: _____ Gender: Female _____ Male _____

Name of Parent/Guardian: _____

Address: _____ Apt. #: _____

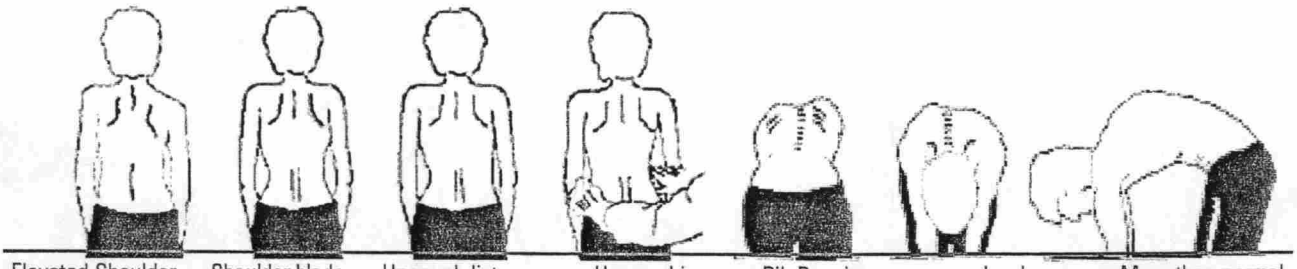
City: _____ State: _____ Zip code: _____

Phone (H): ____ /____ /____ Phone (W): ____ /____ /____

Additional contact information (i.e. cell phone #): ____ /____ /____

Name of School: Overbrook School for the Blind School District: _____

Grade level (circle one): 6 7 8 other _____



	Primary Screener		Secondary Screener	
	Left	Right	Left	Right
Shoulder Elevated				
Shoulder Blade Prominence				
Unequal Distance Between Arm and Body				
Uneven Hips				
Rib Prominence				
Lumbar Prominence				
Kyphosis Increased				

Primary Screening

Date of screening: _____

Negative _____ Referred for 2° screening _____

Screener's name (print): _____

Check one: Volunteer ___ Teacher ___ Clinic Asst. ___

School Nurse ___ Other(Specify) ___

Health Dept. Employee ___

Comments of screener: _____

Secondary Screening

Date of screening: _____

Negative _____ Referred _____

Screener's name (print): _____

Check one: School Nurse ___

Health Dept. Employee ___

Other(Specify) _____

Comments of screener: _____