



Form #4400
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: Date: Signature:

Parent/Guardian - Complete This Portion Only if Student Will Not Be Screened

Opt-out

I do not want my student to be screened for scoliosis at this time.

The student listed above is currently under professional care for scoliosis.

Parent/Guardian's Signature: Date: