



Form #4400
Certificate of Scoliosis Screening

Required for students entering 6th and 8th grade

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:

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: