To be completed by physician:

School Postural Screening Program

Physician's Findings and Recommendations

Name of Student _____ Age _____

Parent Name _____

Address _____

School Nurse _____

School Name _____

Address _____

Date Examined_____

Results of Examination:

_____ No significant findings at this time
_____ Scoliosis
_____ Kyphosis
_____ Referred for further evaluation to_____
_____ Re-examined
_____ Scheduled for re-examination _____
_____ Rescreen in school

Signed _____M.D.

Address _____

Telephone _____

To be completed by physician and returned to the school nurse at the address indicated.