BEEVILLE
INDEPENDENT SCHOOL DISTRICT
INSPIRING BOLD INNOVATIVE LEADERS

SPINAL SCREENING REFERRAL

Dear Parent/Guardian:
Spinal screening was done at your child's school as required by the Texas Department of State Health Services.

It is the recommendation of the school nurse that your child be seen by his/her physician due to:

A. _____ the results of the screening indicate the need for further evaluation of your child's spine by a licensed medical provider.
B. _____ trained staff were not able to complete the screen due to:
   a. ____ Student refused at the time of screening
   b. ____ Parent indicated in writing that screening will be performed by someone else
   c. ____ Student was not able to safely perform the forward bend test.
   d. ____ Parent signed an affidavit of religious exemption.

The spinal screening program is *not* a diagnostic service but does provide screening for spinal problems. The goal is to identify potential spinal problems early and receive medical attention if needed. Not treating spinal problems can lead to serious health problems.

Please take your child to the doctor as soon as possible. Bring this form with you when you go and ask the doctor to fill it out. After your child sees the doctor, please return this form to school.

SPINAL SCREENING RESULTS

Student's Name: _____ Date of Birth: _____ Grade: _____
Campus: _____ Campus Phone Number: _____

Please check any and all that apply:

R	L		R	L	
_____	_____	High Shoulder	_____	_____	Rounded back
_____	_____	Obvious curve of the spine in the lower back	_____	_____	Rib Hump
_____	_____	Shoulder blade stands out more than the other	_____	_____	Hip higher than the other side.
_____	_____	Obvious curve of the spine in area of the rib cage			

Additional comments: _____

Screener's name and Title: _____ Date of Screening: _____

TO BE COMPLETED BY PHYSICIAN

Physician's findings: _____

Diagnosis: _____

Treatment: _____

Referral to specialist: _____

Physical education restrictions: ____ Yes OR ____ No If yes, what restrictions? _____

_____

_____ _____ _____
Physicians' Signature | Printed name of physician | Date