



ABINGTON HEIGHTS

SCHOOL DISTRICT

To: Parents/Guardians of Seventh Grade Student: _____

As a reminder, you selected to have a private scoliosis exam and to comply with the state mandate please return the enclosed form by **May 1st**. Please call the Middle School Nurse at 570-585-4312 with any questions.

Sincerely,

Tina Santaniello, MS, CSN

PHYSICIAN'S FINDINGS

EXAMINATION (Please check)

- ❖ **Scoliosis confirmed**
*x-ray taken
Degree of curve (specify)_____
- ❖ **Possible scoliosis**
No x-ray taken
- ❖ **No Scoliosis**
x-ray taken
- ❖ **No Scoliosis**
No x-ray taken
- ❖ **Other orthopedic conditions**
Confirmed

RECOMMENDATIONS (Please check)

1. Will observe (o) _____
2. Recommended bracing (B)_____
3. Recommend surgery (S)_____
4. Discharged (D) _____

5. Comments _____

Signature _____

Physician (print) _____

Date _____