Chapter 4

Health Screening

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Overview

To address the educational and health needs of students, it is necessary to first assess their physical health and well-being. Health screening techniques allow for early identification of suspected abnormalities. Subsequently, parents and educators can utilize all available health information to plan educational programs and related activities most suited to each student's needs and abilities.

Screening is a traditional part of School Health Services. It centers on vision and hearing since impairment of these senses can interfere with learning, occurs with significant frequency in students, and can be detected with acceptable accuracy by good screening techniques. When referrals from such screening programs result in appropriate examination and corrective measures (which may include classroom placement as well as medical/surgical measures), their value is undeniable.

In addition to vision and hearing, s. 381.0056, F.S. requires provisions for growth and development screening and scoliosis screening.

This type of screening is population based and done on all students designated to receive these screening services, unless parents opt-out in writing. Keep a file of the students that opt out. Individual screening requests by parents or teachers are handled annually on a one-on-one basis.

Populations targeted for mandated screenings are specified in Chapter 64F-6.003, Florida Administrative Code (F.A.C).

- Hearing screening shall be provided, at a minimum, to students in grades kindergarten (K), 1 and 6; to students entering Florida schools for the first time in grades K through 5; and optionally to students in grade 3.
- Vision screening shall be provided, at a minimum, to students in grades K, 1, 3, 6 and students entering Florida schools for the first time in grades K through 5.
- Growth and development screening shall be provided, at a minimum, to students in grades 1, 3, and 6.
- Scoliosis screening shall be provided, at a minimum, to students in grade 6.

Note: Vision and hearing screening should be done for teacher/parent referral of a suspected problem and for students being evaluated for special education placement.

POPULATIONS TO BE SCREENED

Grade	K	1	2	3	6	7	New students to FL: K-5
Vision	x	x		x	x		x
Hearing	x	x		(x)	x		x
Growth & Development		x		x	x		
Body Mass Index (BMI)		x		x	x		
Scoliosis					x		

Optional

Screening Procedures

MASS PRE-SCREENING GUIDELINES

1. **Schedule screening** times and dates in coordination with school administrator.
    - Screenings should be scheduled and completed prior to December.
    - Put the dates on the Master Calendar (you may need to check with administration re: testing schedule)

2. **Coordinate volunteers:**
    - Make contact with your Schools' Volunteer Coordinator.
    - Give the dates of screenings, the numbers of anticipated volunteers required each day. This will depend on whether all grade levels will be screened within the same few days.
    - Communicate the need to schedule 'Screening Training' for volunteers who will assist with screenings. You also may need volunteers to assist with Heights & Weights the week before your screening days. (Health Department Nurse may also assist with the training on this equipment.)
    - Ask your coordinator how reminders to your volunteers can best be accomplished.
    - Ask Health Department Nurse for suggestions on volunteers such as HOSA groups.

3. **<u>Find and schedule</u>** appropriate place for screenings such as library, vacant classrooms, portable, etc.
    - Discuss this need with your Administrator.
    - The testing area must be quiet and fitted with multi service electrical outlets that will accommodate screening equipment and space to allow for 10 foot Snellen charts for vision screening.
    - The screenings need to be done in very close proximity to each other, for proper supervision of trained volunteers and to expedite the process.
    - Confirm with 'screening site' staff prior to the screening for their specific concerns or needs.

4. **<u>Set up screening schedule.</u>**
    - This will be an ongoing work in progress.
    - These are the grades, screenings and times needed to complete each class screening:

K – Vision & Hearing – 20 min. per class
1st -Vision, Hearing– 15 min. per class
3rd – Vision– 15 min. per class
6th –Vision, Hearing, Scoliosis– 25 min. per class
(If Heights and Weights done on the same day, allow an extra 5 minutes per class)

    - Possible resources to develop your schedule are: last years' schedule, the picture schedule or contact your CCHD or peer nurses for advice.
    - Review your draft schedule with your School Administrator before sharing with your teachers.

5. **<u>Communicate</u>** with teaching staff at meetings, e-mail reminders, announcements, notes in boxes, etc. to clarify the date of screening, the importance of promptness, and their responsibility with the process.

6. **<u>Preparing your screening sheets:</u>**
    - Insert screening date on screening sheet and make a copy for every student in grades K, 1, 3, & 6.
    - Contact Lorraine Hans or Vicky Stokely in CCSD Information Services at 284-6507 to request labels to place on screening sheets. Labels should include Name, Student Number, Grade, DOB, & Gender.
    - Labels will come divided into individual classes. Put labels on, keeping them separated by classes. All this can be done by school volunteers.
    - Put labeled screening sheets WITH the screening schedule in the teachers' boxes the night before screenings.

7. **<u>Organizing Heights & Weight Screening:</u>**
    - Determine how this was handled last year.
    - Decide if it can be done the same way this year or you need to improve the process.

- Schedule your equipment to come from the Supervisor of Student Services office at the CCSB Administration and train the users.
- Make a copy of the class rosters for the screeners to use to record requested data.
- If you can, transfer the height and weight data to individual screening sheets. (If this cannot be accomplished before the screenings it can be done the day of screenings by the volunteers.) Height and weights need to be on the screening sheets before they are sent to the Health Department for processing.

8. **The day of screening:**
    - The school nurse/ health designee must be available to run the screening.
    - Please have several copies of the Schedule and volunteers list for the Screening Team.
    - Have a Teacher List with their teachers' # and phone ext.'s.
    - Have 'Health Screenings are TODAY' on the morning &/or daily announcements.

Teachers should be informed about the screenings well in advance because their cooperation is essential. **Students who wear glasses or contacts need to be reminded to wear them for the screening.**

Vision Screening

Overview

Vision Screening and eye examinations are essential for detecting visual impairment. Conditions that lead to visual abnormalities may lead to inadequate school performance and prevent students from obtaining maximum benefits from their educational experience. Undetected impairments of the visual process can lead to potential decrease in learning ability and problems in school adjustment.

Procedures:

- Vision screeners use 10 ft. Snellen Charts or Good Light Charts and Titmus machines.
- Kindergartners who fail must be rescreened on the Snellen Chart in the health room.
- Students who cannot see the critical line for acuity are re-screened (except for Kindergarten) on the Titmus. If they do not pass the initial screening and the re-screening on the Titmus machine, then they are referred.
- Students, who normally wear corrective lenses but do not have them at screening, will be screened without them.
- Upon completion of the screening (including documentation), School Health Designees will receive a list of all students who have been referred.

- A letter requesting an exam by an eye care specialist will be sent to the parents of those students who do not pass the screening. The eye specialist is asked to complete a section of the letter and the parents are to return it to the school health office or school health designee.
- Any family who cannot afford care may be referred to the appropriate community agency for assistance with authorization from the parent.
- At the end of the screening, all of the results are to be entered in the health record. At a minimum, the Kindergarten data should be entered into TERMS on the 406 screen.
- Data should be kept on who has followed up regarding failure notices, so the CCHD School Nurse can input the outcome data in HMS.

Passing Criteria for Vision Screening

Grades:		
Grades:	**Pre-K and K under the age of 6**	**20/40 each eye**
	K over the age of 6 and older	**20/30 each eye**

Hearing Screening

Overview

The purpose of school hearing screening is to identify students with a hearing loss that may affect their intellectual, emotional, social, speech, and/or language development. A subtle hearing loss may be overlooked resulting in developmental or academic delays. Even mild hearing losses may be educationally and medically significant.

Procedures:

- Initial screenings are done on audiometers by the school nurse or those trained by the school nurse.
- Each ear is screened at 25 decibels on 3 frequencies (1000, 2000 and 4000). Failures are re-screened in 2-4 weeks. Pure-tone criteria for failure are not hearing two frequencies in one ear or the same frequency in both ears.
- A letter requesting an exam by the child’s physician is sent to the parents of those students who fail the re-screen. The parent is asked to notify the school health office or health designee of the outcome.
- Any family who cannot afford care may be referred to the appropriate community agency for assistance with authorization from the parent.
- All results are to be entered in the health record. At a minimum, the Kindergarten data should be entered into TERMS on the 406 screen.
- Data should be kept on who has followed up regarding failure notices, so the CCHD School Nurse can input the outcome data in HMS.

Scoliosis Screenings

Overview

Scoliosis is an abnormal curvature of the spine usually developing in pre-adolescents and adolescents during rapid growth spurts. Early detection can prevent scoliosis from progressing and can identify those in need of treatment.

Procedures:

- Screenings are conducted by a Public Health Nurse or trained nurse using a scoliometer.
- All screeners using a scoliometer should adhere to the recommended referral parameter range of 10°or greater.
- Referral letters will be sent home to advise parents of outcomes and recommend physician follow-up.
- All results are to be entered in the health record.
- Data should be kept on who has followed up regarding failure notices so the CCHD School Nurse can input the outcome data in HMS.

Growth & Development Screening

Overview

Height and weight measurements provide a simple, effective method of identifying potential childhood health problems. These measurements can be used as an educational tool for parents, students, and school personnel.

Height and Weight Screening Process

- These measurements will be conducted at the individual school by a team designated by the school administration.
- A digital scale and stadiometer are available through Student Services at the CCSB Administration office.
- An inservice of its use may be coordinated with the CCHD School Team.
- The data should be collected on homeroom class lists, and then given to the School Health designee.
- Height should be recorded in inches to ¼”
- Weight should be recorded in pounds to 0.1 lbs.
- This information is then recorded on the screening form and used for BMI calculation. Height and weights need to be on the screening sheets before they are sent to the Health Department for processing.

Body Mass Index Screening

Overview

BMI is a screening tool used to identify individuals who are underweight or overweight. BMI is the recommended screening method for children and adolescents.
It is based on a child's age and gender calculated using height and weight compared to standardized growth charts. This calculation determines if the child is in the normal range for height and weight or outside the norm, and identifies individuals who may have increased potential to develop certain chronic diseases during childhood or adulthood.

Screening Guidelines:
BMI-for-Age Parameters as per CDC recommendations

- >95th percentile Obese
- 85th to 95th percentile Overweight
- 5th to 85th percentile Normal
- <5th percentile Underweight

Parents will receive results on screened children with explanations and recommendations.

School Health Information Program (SHIP)

The Clay County Health Dept School Team coordinates data entry of all screening data into the State approved School Health Information Program (SHIP).

This program generates a "health report card" of the screening results for each student screened. The report cards, as well as referral letters, are sent home with each student.

CLAY COUNTY HEALTH DEPARTMENT

School____________________
Student ID#________________
Name_____________________
GD____Teacher______________
Affix Health Screening Label

Individual Screening Results Entry Form

DATE OF MASS SCREENING
___/___/___
No Permission ☐
New Student ☐
Absent ☐

Clay County
HEALTH DEPARTMENT
HEALTH

VISION

Child wears prescription glasses/contacts
Worn for test ☐ Left at home ☐ Broken / Lost ☐

Test 1 SNELLEN RESULTS: PASS ☐ FAIL ☐

Test 2 TITMUS RESULTS: PASS ☐ FAIL ☐

TEST #1
RIGHT 20/ ______
LEFT 20/ ______

TEST #2
RIGHT 20/ _______
LEFT 20/ _______

VISION REFERRAL ☐

Comments ____________________

HEARING PURE TONE

TEST 1
RESULTS: PASS ☐
FAIL ☐

RIGHT db	LEFT db
1000 ______	1000 ______
2000 ______	2000 ______
4000 ______	4000 ______

REQUIRES RESCREEN ☐ Record child's threshold db for each frequency (Ex. 1000 45db)
Rescreen student 3-4 weeks

TEST 2 Date Test #2 ___/___/___
RESULTS: PASS ☐
FAIL ☐

RIGHT db	LEFT db
1000 ______	1000 ______
2000 ______	2000 ______
4000 ______	4000 ______

HEARING REFERRAL ☐
Comments ____________________

GROWTH / DEVELOPMENT

Date of Test
___/___/___

HEIGHT IN INCHES _______
(2 decimal places ex. 43.75 in.)
Record Partial in. as decimals (1/2 in. = .50 etc.)
Round DOWN to nearest quarter inch.
Ex: 1/8 in. record as .00 inches , 3/8 record as .25, 5/8 record as .50, 7/8 record as .75

WEIGHT IN LBS. ________
(1 decimal place)
(Actual Reading)
Ex: 90.5 lb.

Referral made if BMI for age percentile is < 5% (underweight)
OR > 95% (overweight.)

Comments ____________________

REV 7/28/09

SCOLIOSIS

Date of Test
___/___/___

RESULTS: PASS ☐
FAIL ☐

SCOLIOSIS REFERRAL ☐

Comments ____________________

Original Copy to Cumulative File

Example of Screening Report Card sent to parents:

Tuesday, June 24, 2008

To the Parents of:

Student ID:

School Name:

Teacher:

Your child recently participated in the school-based health screening activities required by Florida Law. The Clay County Health Department and your child's school, working in partnership, conducted the screenings. The screening included the evaluation of your childs Vision, Hearing, Scoliosis and Growth and Development according to what was required by State Law for your childs age group and as you permitted.

This is the "Report Card" resulting from the screening. The following are the results of the screenings performed on your child. Some screenings were not done because they were not required, or you requested they not be done.

The actual height and weight measured, as well as the calculated Body Mass Index (BMI) and Body Mass Index for Age Percentile (BMI%) can be seen in the information below. The explanation for these evaluations can be found on the back of this page. The screening results may indicate the possibility of a health issue to discuss with your health care provider.

Growth and Development	*Height*	*Weight*	*BMI*	*BMI%*
Vision	*Far* R 20 L 20/	*Near* R 20 L 20/		
Hearing				
Scoliosis				

If your child has been referred for additional care in any of the screening area's and you are having difficulty accessing care, please contact the School Health Program of the Clay County Health Department at 904-529-2854. Please notify your child's teacher or school nurse if/when you obtain medical care for your child's referral.

How to Read Your Child's Screening Results

What is BMI?

Body Mass Index, BMI, provides a guideline, based on weight and height, to help judge whether a person's weight is within a healthy range for their height. Additionally, the normal amount of fat differs in girls and boys as they mature. The **BMI for Age Percentile** uses the **BMI** to adjust for the differences between ages, and gender (boys and girls). It is the **BMI for Age Percentile** that identifies if a health risk exists.

BMI for age Percentile	What it Means	Recommendation
Less than the 5th percentile	**Underweight**	**Medical Assessment**
Greater than or equal to the 5th to the 84th percentile	**Healthy Weight**	**No action needed**
Greater than or equal to 85th percentile to the 94th percentile	**Overweight**	**Medical Assessment if other risks exist (Family History, heart disease, diabetes, etc.)**
Greater than or equal to 95th percentile	**Obese**	**Medical Assessment**

If the BMI for age percentile is greater than or equal to the 95th percentile, it tells you that 95 % of other children, whose sex and age are the same, are considered to be in a healthier weight range. Greater than or equal to the 95th percentile is considered **obese** and at risk for health problems. If this situation exists, a medical evaluation and intervention is recommended. This guideline is established by the national Centers for Disease Control (CDC).

BMI for Age Percentile is related to health risks

Obese children are likely to become overweight adults. 60 percent of children and teens with a BMI-for-Age Percentile above the 95th percentile (obese) have at least one risk factor, while 20 percent have two or more risk factors for future cardiovascular disease such as heart attack and stroke. Risks in childhood include acquired diabetes type II and reduced cardiovascular health.

Underweight children need to be monitored even if their growth is normal. Children need good nutrition for good growth and development.

If your child's results fall in the less than 5%, or, greater than or equal to 95% for BMI for age Percentile, and, you have chosen to have your child evaluated by a medical provider, please notify your school nurse. It is only through your notification that we can evaluate the outcomes of the screening efforts.

Growth and Development Follow-up Evaluation Notification

Dear Parent or Guardian,

The Growth and Development result information and the recommendations based on the child's BMI for Age Percentile are provided to aid parents/guardians in obtaining health care for the child, according to the need.

Parent / Guardian Reply

I choose not to obtain a health care provider's evaluation for the report covering: **Child's Name:________________________School:__________________________.**

Signed____________________________________ Date________________

Health Care Provider's Report (To be completed by the Health Care Provider rendering evaluation and care) **Child's Name:________________________School:__________________________.**

Findings/Plan:____

____

Provider Name________________________Signature___________________Date_____

Please return to: your child's school nurse.

Clay County School District

Teacher _______________________________Date __________________________

Please send ____________________________________ to the health room at your earliest convenience for vision and hearing screening.

Thank you,

CLAY COUNTY DISTRICT SCHOOLS and
CLAY COUNTY HEALTH DEPARTMENT
SCHOOL HEALTH SERVICES

Vision Referral Log

School ______________ Teacher: _________________________ Grade ______ Date ______________________

The following is a listing of the students in your class who did not pass the vision screening recently conducted at your school. The parents of these students are being notified. Some of your students may also be re-screened for possible hearing problems in the coming weeks. If you receive information that a student has seen an eye doctor, or if you have a student in need of assistance, please advise your school nurse.

Student Name	Student Number	Vision Results	Saw Eye Doctor	Received Glasses/ Contacts
		R 20/ L 20/		
		R 20/ L 20/		
		R 20/ L 20/		
		R 20/ L 20/		
		R 20/ L 20/		
		R 20/ L 20/		
		R 20/ L 20/		
		R 20/ L 20/		
		R 20/ L 20/		
		R 20/ L 20/		
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		R 20/ L 20/		
		R 20/ L 20/		
		R 20/ L 20/		
		R 20/ L 20/		

CLAY COUNTY DISTRICT SCHOOLS and
CLAY COUNTY HEALTH DEPARTMENT
SCHOOL HEALTH SERVICES

REFERRAL FOR VISION EXAMINATION

REPORT TO PARENTS

School____ Teacher ___________________________________

Child's Name ___________________________________ Grade ________ Date ______________________

Your child's eyes were screened by the school nurse as one of the health services provided by this school in order to identify students who have vision problems or might be at risk for vision problems. The vision of students is very important, especially for classroom learning, so it is important to identify any barrier to learning that can be corrected.

Your child's school vision screening results suggest that he/she should have a complete professional eye exam. It is important to your child's school success to have a professional evaluation. If a problem is found and corrected, it may help your student do better in his/her school work.

Just because there are no complaints about vision, you should not assume that your child has perfect vision. Often children do not know they should be able to see better than they do.

Results of school screening with glasses R 20/ ____ L 20/_____

Results of school screening without glasses R 20/ ____ L 20/_____

Financial assistance may be available through various agencies for those unable to pay. Please contact me at ___________________________ if finances are a concern and you do NOT have insurance, need help in getting the eye exam, or your child is already under a doctor's care for vision problems.

____
School Nurse Signature

DOCTOR'S REPORT TO SCHOOL

Date of eye exam ___________________

Visual acuity without glasses R 20/ ____ L 20/_____

Visual acuity with glasses R 20/ ____ L 20/_____

Diagnosis ____

No glasses needed ________ Correction prescribed: Glasses __________ Contact lenses ____________

Glasses are to be worn for: Consistent Use _____ Near Vision Only _____ Distance Vision Only _______

Comments or suggestions as to specific needs for child's school program (equipment, seating):

____

Physician's Signature _____________________________

Address _______________________________________

CLAY COUNTY DISTRICT SCHOOLS and
CLAY COUNTY HEALTH DEPARTMENT
SCHOOL HEALTH SERVICES

SCHOOL HEALTH REFERRAL
VISION FOLLOW-UP
(2nd notice)

School____ Grade ____________________________

Child's Name _________________________________ Teacher __________________________

Dear Parent,

About a month ago, I sent home a note recommending that your son or daughter have an eye examination to determine if glasses are needed. Please answer the questions below and return it to the health room to let me know what follow-up has happened or is planned. If financial issues prevent you from seeking this health care, please call me. If I am not available please leave your name and number and a convenient time to return your call and I will call you back. If I have not heard from you within 30 days, the public health nurse will contact you by phone. If you have any questions, please call me at the number below. Thank you.

Sincerely,

____
School Health Nurse

____
Phone Number

Doctor's examination was obtained. ___YES ____NO
If YES:

Were glasses needed? ___YES ____NO
If yes, were glasses obtained? ___YES ____NO

If NO:
Doctor's Appointment has been made for ___________________________________.

____
Parent's Signature

CLAY COUNTY DISTRICT SCHOOLS and
CLAY COUNTY HEALTH DEPARTMENT
SCHOOL HEALTH SERVICES

School ____________________________ **Date** ____________________

Hearing Failure Worksheet

Student	Student Number	Teacher	Grade	R results	L results	Saw Dr.	Outcome
				1000 _____ 2000 _____ 4000______	1000 _____ 2000 _____ 4000______		
				1000 _____ 2000 _____ 4000______	1000 _____ 2000 _____ 4000______		
				1000 _____ 2000 _____ 4000______	1000 _____ 2000 _____ 4000______		
				1000 _____ 2000 _____ 4000______	1000 _____ 2000 _____ 4000______		
				1000 _____ 2000 _____ 4000______	1000 _____ 2000 _____ 4000______		
				1000 _____ 2000 _____ 4000______	1000 _____ 2000 _____ 4000______		
				1000 _____ 2000 _____ 4000______	1000 _____ 2000 _____ 4000______		
				1000 _____ 2000 _____ 4000______	1000 _____ 2000 _____ 4000______		
				1000 _____ 2000 _____ 4000______	1000 _____ 2000 _____ 4000______		
				1000 _____ 2000 _____ 4000______	1000 _____ 2000 _____ 4000______		
				1000 _____ 2000 _____ 4000______	1000 _____ 2000 _____ 4000______		
				1000 _____ 2000 _____ 4000______	1000 _____ 2000 _____ 4000______		

CLAY COUNTY DISTRICT SCHOOLS and
CLAY COUNTY HEALTH DEPARTMENT
SCHOOL HEALTH SERVICES

REFERRAL FOR HEARING EXAMINATION

REPORT TO PARENTS

School____ Teacher ___________________________

Child's Name _______________________________ Grade ________ Date ____________________

The School Health Services program routinely screens students for possible hearing problems in order to identify any difficulty to learning that might be corrected. Screening programs are important for these reasons:

- They identify students with possible hearing problems.
- Temporary hearing loss causes students to miss essential instructions in the classroom.
- Parents may not be aware of a child's mild hearing loss in every day home situations.
- Even mild losses may interfere with learning new vocabulary, which is important for success in Reading.
- Hearing loss is invisible and the child may be blamed for not paying attention.
- Hearing loss may be sign of ear disease.
- Children with very mild losses or loss in only one ear may be experiencing school failure.

Your child failed our screening and rescreening for hearing problems. It is important to your child's school success to have a professional evaluation. If a problem is found and corrected, it may help your child to do better in his or her school work. Enclosed is a referral form to take to your physician or speech and language specialist. It is important to us to know the outcome of the professional examination, so please return the form to us with the results of the exam. If there are circumstances that prevent you from taking your child to the doctor, your child is already under a doctor's care, or if you have any questions, please call your school nurse.

____
School Nurse Signature

DOCTOR'S REPORT TO SCHOOL

Please provide the school nurse named above with the results of this evaluation so that the school may be informed and make any necessary adaptations and/or do monitoring of the child's condition.

____

____

____

____
Physician's Signature Date

____
Address

CLAY COUNTY DISTRICT SCHOOLS and
CLAY COUNTY HEALTH DEPARTMENT
SCHOOL HEALTH SERVICES

SCHOOL HEALTH REFERRAL
HEARING FOLLOW-UP
(2nd notice)

School____ Grade ______________________

Child's Name _________________________________ Teacher _____________________

Dear Parent,

About a month ago, I sent home a note recommending that your son or daughter have an examination by a physician or Speech and Hearing Specialist of your choice to determine if your child has an actual hearing loss. Please answer the questions below and return it to the health room to let me know what follow-up has happened or is planned. If financial issues prevent you from seeking this health care please call me. If I am not available please leave your name and number and a convenient time to return your call and I will call you back. If I have not heard from you within 2 weeks, the public health nurse will contact you by phone. If you have any questions, please call me at the number below. Thank you.

Sincerely,

____
School Health Nurse

____
Phone number

Doctor's examination was obtained. ____YES ____NO
If YES:
Was a hearing deficit confirmed? ____YES ____NO
Was treatment obtained? ____YES ____NO
Please explain:
____

____

If NO:
Doctor's Appointment has been made for ____.

____
Parent's Signature

CLAY COUNTY DISTRICT SCHOOLS and
CLAY COUNTY HEALTH DEPARTMENT
SCHOOL HEALTH SERVICES

School ___________________________ Date ____________________

Scoliosis Failure Worksheet

Student	Student Number	Teacher	Saw Dr.	Outcome

CLAY COUNTY DISTRICT SCHOOLS and
CLAY COUNTY HEALTH DEPARTMENT
SCHOOL HEALTH SERVICES

SCHOOL HEALTH REFERRAL
SCOLIOSIS FOLLOW-UP
(2nd notice)

School____ Grade ______________________

Child's Name _________________________________ Teacher ____________________

Dear Parent,

About a month ago, I sent home a note recommending that your son or daughter have an examination by a physician to determine if your child has an actual abnormality of the spine. Please answer the questions below and return it to the health room to let me know what follow-up has happened or is planned. If financial issues prevent you from seeking this health care, please call me. If I am not available please leave your name and number and a convenient time to return your call and I will call you back. If I have not heard from you within 2 weeks, the public health nurse will contact you by phone. If you have any questions, please call me at the number below. Thank you.

Sincerely,

____
School Health Nurse

____
Phone number

Doctor's examination was obtained. ____YES ____NO

If YES:

Was an abnormality of the spine confirmed? ____YES ____NO

Was treatment obtained? ____YES ____NO

Please explain:

____

____

If NO:

Doctor's Appointment has been made for ____.

____
Parent's Signature