Notre Dame Junior/Senior High School

60 Spangenburg Avenue

East Stroudsburg, Pennsylvania 18301

Private Physician's Scoliosis Screening

Student's Name________________________________ Sex_____ Grade_____ Date________________

PHYSICIAN'S FINDINGS

EXAMINATION (Please circle)

1. Scoliosis confirmed
   *X-ray taken
   Degree of curve (specify) ____________
2. Possible Scoliosis
   No X-ray taken
3. No Scoliosis
   X-ray taken
4. No Scoliosis
   No X-ray taken
5. Other orthopedic conditions
   confirmed

RECOMMENDATIONS (Please circle)

1. Will observe
2. Recommend bracing
3. Recommend surgery
4. Discharged
5. Comments________________________________
   ____

Signature________________________________

Physician (print)____________________________

Telephone________________________________

Date____________________________________

*Single erect AP X-ray for baseline recommended by the American Academy of Orthopedic Surgeons.