

**MANSFIELD MIDDLE SCHOOL  
School Health Services**

**Parent Information: Scoliosis Screening**

Screening for scoliosis will be conducted in grades 5 through 8 in November and December, 2015. This screening is mandated by the State of Connecticut for all students in grades 5-8 but can be declined by a parent/guardian (see below). The screening will be conducted by the school nurses or trained physical education teachers during scheduled PE classes at MMS.

The objective of the screening is early detection of spinal deviations (scoliosis). Scoliosis is most easily identified during years of rapid growth. If detected in its early stages, during the growth years, exercises or a brace may be all that is necessary to prevent further curvature. If not detected and treated early, the curvature can become great enough to affect a person's health and appearance.

The procedure for screening is a simple one and is privately done on an individual basis. The child's spine is viewed as he or she stands and bends forward. Girls must be wearing a bra, a form-fitting camisole, or bathing suit top along with their gym shorts/pants. Please have them bring this in with their gym clothes. Girls will be screened by female PE teachers or nurses. Boys will be screened without their shirt and wearing gym shorts/pants. Boys will be screened by a male PE teacher or a school nurse. Girls and boys are screened in separate locations.

Parents or guardians of students who are found to have signs of a possible spinal abnormality will be notified in writing with recommendations for further evaluation.

If your child is currently under treatment for a spinal deviation or if you prefer to decline this screening, please complete the statements below and return the lower portion of the form to the health room. If you have any questions about the screening procedures, please call the health office at 860-429-9341 ext. 7154.

Karen Molloy, RN  
School Nurse

Erin Bayne, RN  
School Nurse

**Return this portion only if you wish to DECLINE screening.** (Check reason below)

\_\_\_\_\_ **Student Name**

\_\_\_\_\_ **Grade**

**Postural screening at school DECLINED by parent/guardian.**

**My child has a diagnosed postural deviation and is being followed by a medical provider.**

Date of last Doctor's Exam: \_\_\_\_\_ Doctor's Name: \_\_\_\_\_

Treatment prescribed:  
\_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date