Scoliosis Screening Release Form

The Florida Department of Education requires a Scoliosis Screening for **all 6th graders** in accordance with Section 1003.22 (4), Florida Statutes, and State Department of Health Rule 64F-6.003, Florida Administrative Code.

Please have your student receive this screening through his General Practitioner or Pediatrician and return the Scoliosis Screening Release Form to the school office.

Date ____/____/____

Name of Child: _____ DOB: _____

To be completed and signed by Health Care Provider ONLY:

The child named above has had a completed Scoliosis Screening on the following date: ____/____/____

Screening Results: _____

Signature/ Title of Health Care Provider: _____

Date: ____/____/____

Name (Please print or stamp)

Address (Please print or stamp)