Gamble Rogers Middle School

Greg Bergamasco
Principal

6250 US 1 South St. Augustine Florida 32086
Telephone (904) 547-8700 Fax (904) 547-8705
www-grms.stjohns.k12.fl.us

Deb Donlan
Assistant Principal

Dear Parent/Guardian:

In compliance with Florida Statute 381.0056(5a), regarding school health services, screenings for vision, hearing, and height/weight and scoliosis will be conducted at your child's school beginning September 1, 2017. The purpose of scoliosis screening is to detect signs of spinal curvature at the earliest stages so that the need for treatment can be determined.

Scoliosis, the most common spinal abnormality, is a side-to-side curve of the spine. It is usually detected in childhood or early adolescence. Most cases of spinal curvature are mild and require only ongoing observation by a physician after the diagnosis has been made. Mild curvatures are often noticeable only to those trained in detecting spinal abnormalities. Others may become progressively more severe as the child continues to grow. Early treatment can prevent the development of a severe deformity, which can later affect the health, and appearance of the child.

The procedure for screening is simple. A registered nurse will look at your child's back while he/she stands and bends forward. For this screening, each student will be seen individually in a private room. In order to assure accuracy of screening, students will be asked to lift their shirts to upper back level.

You will be notified *only* if medical follow-up is necessary. This screening does not replace your child's need for regular health care and check-ups.

If you **do not** wish your child to receive the postural screening, please sign the first option below and return it to your child's school **PRIOR** to screening. If you **do not** wish your child to participate in any part of the health screening (height/weight, vision, hearing, and postural), please sign the second option below and return it to your child's school **PRIOR** to screening.

Sincerely,
Kendell Hardwick, RN

Only sign below if you do not want your child to be screened.

••

School: ______________________ Grade: ________

1. Please **do not** include my child, ____________________________, in the scoliosis screening to be held at school by trained personnel.

____________________________ ____________________________ ____________

Parent Name (Printed) Signature of Parent Date

2. Please **do not** include my child, ____________________________, in any of the health screening process (height/weight, vision, hearing, or scoliosis) please sign below:

____________________________ ____________________________ ____________

Parent Name (Printed) Signature of Parent Date