LIBERTY PINES ACADEMY

"ON THE PROWL FOR ACADEMIC EXCELLENCE"

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ONLY SIGN BELOW IF YOU DO NOT WISH YOUR CHILD TO BE SCREENED

Dear Parent/Guardian: August 2016

In compliance with Florida Statute 381.0056(5a), regarding school health services, we are notifying you that students in the St. Johns County School System will be offered free screening for vision, hearing, and height/weight measurement for growth and development. A screening for scoliosis is also given. The purpose of the 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 trained medical person will look at your child's back while he/she stands and bends forward in a diving position. For this screening, each student will be seen individually in a private room. In order to assure accuracy of screening, students may be asked to lift the back of 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.

Your child will be screened unless you notify the school, in writing by signing below, no later than August 26, 2016, that you do not want your child to participate. If you **do not** wish your child to receive the scoliosis 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 scoliosis), please sign the second option below and return it to your child's school **PRIOR** to screening.

Sincerely,
Judith Thayer
Principal

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ONLY SIGN BELOW OPTION 1 OR 2 IF YOU DO NOT WISH YOUR CHILD TO BE SCREENED.

1. Please **DO NOT** include my child, _____, in the **scoliosis screening only**._____ _____ _____
   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):
   _____ _____ _____
   Parent Name (Printed) Signature of Parent Date