

Spinal Screening Deferral
Grades 6,7,8

Please check the appropriate box, sign and return to the Health Office:

- I DO NOT** want my child checked during spinal screening because his /her physician does this screening.
- My child is already under treatment for spinal deformity and does not need to be screened.

Student Name _____ Homeroom _____

Signature of Parent _____ Date _____

This form MUST be in the Health Office by February 1st each screening year