



HOLY TRINITY SCHOOL



PreK 2 to Grade 8

336 First Street, Westfield, NJ 0709
Ph. 908-233-0484 | Fax 908-233-6204

Dear Parents/Guardians,

I will be conducting a scoliosis-screening for students age 10 and over **in grades five and seven** as required by N.J. State law. **The screening will be done during your child's gym class during the month of March.** *Consent to perform the scoliosis screening is required.*

Scoliosis is a condition in which the spine may curve to the left or to the right. It is most commonly found during the time of rapid growth and may progress if not treated. The purpose of this program is to recognize scoliosis in its earliest stages.

A student may be exempt from this screening if requested by the parent/guardian, in writing. This notice must be returned to school by **February 27th in order for your child to be screened.** Please indicate if you do or do not want your child screened.

The student's clothing must allow the screener to view the student's spine for physical findings. *During the month of March, please have your child dress appropriately for this screening on their assigned gym day.*

GIRLS: Should wear a bra, halter top or swimsuit top that allows full view of the spine.
NO CAMISOLES OR UNDERSHIRTS PLEASE.

BOYS: Should wear a polo shirt or gym shirt.

Parents will be informed of any suspected problems.

Thank you,
Mary Kaiserman RN BSN
908-233-1145

Return this portion no later than February 27th

_____ **Student's Name**

Grade_____

_____ I give permission for my child to be screened by the school nurse for scoliosis.

_____ **I DO NOT** give permission for the screening. My child will be examined by our private physician.

Signature Parent/Guardian



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