SCREENING PROGRAMS

704 KAR 4:020 School Health Services, Section 2

(11) A board of education shall adopt a program of continuous health supervision for all school enrollees. Supervision shall include scheduled, appropriate screening tests for vision, hearing and scoliosis. *

(12) A local spinal screening program for scoliosis shall include:

(a) Training sessions for teachers or lay volunteers who will be doing the screening;

(b) Obtaining parental permission for scoliosis screening;

(c) Established screening times, at least in grades six (6) and eight (8) and appropriate procedures and referral criteria;

(d) Mandated education of students regarding scoliosis screening; and

(e) Required referral of all children with abnormal screening results for appropriate diagnosis and treatment and follow-up on these referrals. Local referral and follow-up procedures shall include:

1. Notification of parents of students who need further evaluation by a physician;

2. Tracking referrals to determine whether all children with abnormal screening results receive appropriate diagnosis and treatment; and

3. Reporting of data on screening, referral and follow-up tracking to the Department of Education.

(13) The Department of Education shall:

(a) Monitor the spinal screening and referral programs provided by local boards of education;

(b) Provide consultation and technical assistance to local boards of education concerning spinal screening, referral and follow-up for appropriate diagnosis and treatment; and

(c) Encourage local school systems to work cooperatively with local health departments and local Commission for Children with Special Health Care Needs offices to plan, promote and implement scoliosis screening programs.

(14) Referral and appropriate follow-up of any abnormality noted by screening assessment or teacher observation shall be recorded on school health records.

*Note: Only scoliosis is mandated in this regulation to be performed at grades six (6) and eight (8). The specific scheduling (grades) of vision and hearing is at the local district's discretion.

Documentation of all health screenings will be recorded on the Pupil's Cumulative Health Record (Exhibit 3I). The following guidelines are for reference only and not intended to take the place of a formal training session for persons performing screenings.

Scoliosis Screening

Scoliosis, or lateral curvature of the spine, is a common disorder. The majority of curves are of unknown origin although there appears to be a strong familiar tendency. Scoliosis can affect adults, but it is most common in young people, especially girls between ages of 10 and 16 (Green WB, et al. (2001). [(8)] Although many curves can be of minor consequence, progressive scoliosis may lead to crippling spine deformity and heart and lung problems; therefore, early detection and treatment are essential.

The purpose of a school screening is primarily to identify the child at risk of persistent asymmetry, not to diagnose a spinal deformity. Scoliosis often goes undetected because of the painless onset. Unless the condition is severe, it will not be visible to parents or otherwise in a clothed child. Early detection can be accomplished by mass screening of the critical age groups by trained personnel. The Kentucky Commission for Children with Special Health Care Needs recommends school age children in grades 5-9 be screened yearly. The law requires 6th and 8th grades be screened annually (704 KAR 4:020 (2)(12).

Steps in Setting Up a Scoliosis Screening

1. Designate a coordinator who will organize and implement the spinal screening program by arranging for screening training, student education, parent permission, dates for screening, and follow-up on findings of screening and prepare reports for Department of Education.
2. Coordinators and other screeners should attend a training session if they have not participated previously. School personnel and community health departments are encouraged to work together where possible. Videotape is available for loan from Commission for Children with Special Health Care Needs (CCSHCN), which provides instruction for screeners. (See Exhibit 3J-School Screening for Scoliosis: Screening Procedure Worksheet) Use of trained health aides or volunteers is appropriate and encouraged for initial mass screening. However, nurses, physicians, or other appropriately trained professionals should perform all rescreenings.
3. Coordinators must obtain parental permission for screening or rescreening. (Exhibit 3K)
4. Students must be educated prior to screening to alleviate undue anxiety and give them the opportunity to dress appropriately. A tape for children is available by loan from the Commission for Children with Special Health Care Needs (CCSHCN), which explains what scoliosis is, how it is detected, why it is important to screen and act on positive findings.
5. Privacy for screening is a top priority. Boys and girls should be screened separately and individually. Students should be barefoot. Boys should remove their shirts. Girls may place their blouses on backwards.
6. List every student on the Scoliosis Screening Worksheet found in the packet (Exhibit 3L). Any abnormal findings should be listed under R- (rescreening). Whenever possible to avoid unnecessary referrals to physician, students with positive findings should be rescreened by a health professional.
7. After all of the initial screenings are completed, including absentees, the local coordinator makes arrangements for the rescreening. This step may be omitted if a doctor or registered nurse does the initial screening.
8. Included in this section is the "Criteria for Referral to Physicians". It is used by second screeners as a guide on which to base the referrals. It is recommended nurses use a scoliometer to aid in decisions to refer.

9. Good communication is essential. Parents should understand that a positive screening does not constitute a diagnosis of scoliosis but indicates a need for further evaluation by a physician. The person who does the referral screening gives the findings to the coordinator. (Exhibit 3M-Master List) Parents of students who need further evaluation by a physician should be notified. The coordinator should send this information on a referral letter to the parents with an explanation of findings. (Exhibit 3N)
10. Those needing financial assistance for physician evaluation may be referred to the Kentucky Commission for Children with Special Health Care Needs, (800) 232-1160, for evaluation by an orthopedist.
11. The physician completes the referral letter with his findings and returns it to the local coordinator. A copy should be kept and the originals placed in the student's health record.
12. Students with questionable findings who are not referred for evaluation should be rescreened in 4-6 months or during the yearly screening process. The coordinator can keep a master list of students who will need rescreening. Parents should be notified that their child failed this screening. [10]
13. The coordinator in public schools should report screening numbers to Department of Education, who in turn with share with the Commission. Coordinators in private schools should send a Scoliosis Screening Report to the CCSHCN, 982 Eastern Parkway, Louisville, KY 40217 by July 1.
14. Resources that are available for parents, students and health professionals are provided or are available from National Scoliosis Foundation website (http://www.scoliosis.org/)

Scoliosis Screening Process

While not an absolute "measurement", scoliosis screening is conducted as a part of a Preventative Health Assessment at certain ages. Using the appropriate procedure for this screening is essential and is included here for that reason.

1. Watch the child walk toward you, then turn and walk away. Notice any signs of leg length discrepancies. With back bare, the child should stand straight, feet together, looking straight ahead, arms at his/her side. Examiner will look for the following:

    a) Head: to see if it is centered over the pelvis (a plumb line may be helpful in checking this)
    b) Alignment: Does the head and base of the neck line up over the center of the sacrum?
    c) Shoulders: to see if they are level;(Is one shoulder higher or lower than the other side or is there a fullness on one side of the neck?)
    d) Scapulas (shoulder blades): to see if one is more prominent than the other
    e) Arms: to see if they are equal distance from the sides; (Is there a greater distance between the arm and flank on one side or the other?)
    f) Waist: to see if the indentions (waist side curves) are the same; (Is there a deeper crease over one side of the waist than the other?)
    g) Spine: as noted by observing the spinous processes; (Does it appear to curve?)
    h) Hips: to see if they are level; (Is there an asymmetrical contour of the flanks and hips?)
    i) The child should then bend forward with head down, the back parallel to the floor and their hands clasped; (Is there prominence or a bulge on one side of the back or flank?)

2. View the child from the side, looking for

    a) One shoulder higher than the other
    b) Head not centered directly over pelvis
    c) One hip appears raised or more prominent than the other
    d) Uneven wrist
    e) Leaning of entire body to one side

Any one of the findings suggests an underlying scoliosis curve, which deserves further evaluation.

The Scoliometer is a device that provides a way to measure the angle of trunk rotation in spinal screening for scoliosis. The Scoliometer should not be used in place of the screening previously described, but if used in concert with the routine screening, it will provide objective guidelines for referral. The scoliometer will also reveal small curvatures, which do not require a referral, but will need follow-up rescreening. Manufacturer's guidelines should be followed when using the scoliometer for spinal screenings.

Criteria For Referral

The following criteria for referral is used by second screeners as a guide on which to base referrals. If any child has any three of the following, the child should be referred to a pediatrician, family doctor, or the Commission for Children with Special Health Care Needs (CCSHCN).

1. One shoulder higher than the other
2. One scapula more prominent than the other
3. Waist folds not even
4. Arms not hanging equal distance from the sides
5. Pelvis not level
6. Unequal symmetry of the upper back, lower back or both

If any one or two of the above are seen, then the child should be re-screened in 6-12 months. If the child, on forward bend test, has a hump on one side hat measures less than 7 degrees, using the scoliometer, the child should be re-screened in 6-12 months.

Hearing Screening

According to 704 KAR 4:020(2)(11), the Board of Education shall adopt a program of continuous health supervision that includes scheduled screening tests for hearing. *(Note: This regulation does not mandate when the school district must perform this screening. The determination of when to screen is left up to the individual school district to schedule.)*

Hearing is assessed in children 3 years and older (depending on understanding and cooperativeness), adolescents, and adults with pure tone screening (audiometers). If unable to test the child using the pure tone screening procedure, assess the hearing as described for younger children. Refer to the Health Matrix for frequency of screening. (Exhibit 3A)

Testing Area

The room used for hearing screening should be as quiet as possible, because background noise interferes with the accuracy of the test and leads to false positive results. Examples of background noise are hallways, fluorescent light hum, etc. The tester, who has normal hearing, may test him/herself to be sure that ambient noise does not interfere with testing. The testing room must be at least large enough to accommodate a table for the audiometer and chairs for the tester and patient. The patient's chair should be positioned so that the patient cannot see the operation of the audiometer.

Pure Tone Screening Procedure

A: Audiometer

1. Power: Turn on.
2. Masking: Check to insure that masking is turned off.
3. Output Selector: Red earphone is for the right ear (Hint: R for R)
   Blue earphone is for the left ear.
4. Tone Level or Tone Interrupter: Normally Off. Press down to produce tone.
5. The following test levels shall be followed for these frequencies:
   a. 1000Hz 2000Hz 4000Hz
   b. 20dB 20dB 20dB
   c. 25dB for exam room
6. Patients being tested with pure tone audiometer are given verbal instructions to raise their hand when the tone is hears. Children age 6 and below may be able to raise their hand, but it is often easier to have them drop a block. Children below age 6 should have a demonstration: Place the headphones on the table or in your lap, present a tone at 90dB and raise your hand/drop a block. Repeat this having the child perform with you simultaneously. Repeat the tone, but allow the child to perform alone. TURN THE TONE BACK DOWN to 20dB, then place the headphones on the child (adolescent, adult) and proceed with the specified test levels.

B: Screening

1. Set frequency dial to 1000Hz.
2. Set hearing level at 20dB
3. Present the tone by pressing the tone level.
4. To be assured that the patient is responding correctly, the tone may need to be presented several times. Once the desired response is received (i.e. drop a block/raised hand), continue the test and complete the screening as follows:
   a. Sound Proof Room
      i. Test right eat at 1000, 2000, and 4000 Hz at 20dB
      ii. Test left ear at 1000, 2000 and 4000 Hz at 20dB
   b. Exam Room Area
      i. Test right ear at 1000, 2000 and 4000 Hz at 25dB
      ii. Test left ear at 1000, 2000 and 4000 Hz at 25dB
5. If the patient DOES NOT RESPOND to the first tone presented in the right ear and if the patient DOES NOT RESPOND to the first tone presented in the right ear at 1000 Hz at 20dB (25dB) then:
   a. Increase the hearing level to 30dB (leave on right ear at 1000 Hz)
   b. If no response then increase to 40dB
   c. If no response then increase to 50dB
   d. If no response, then switch the control to the left ear and follow the same procedure, increase by 10dB and decrease by 5dB.

6. Normal hearing test per audiometer:
   20dB each ear, each tone-sound proof room
   25dB each ear, each tone, exam room area

C. Pass/Fail Criteria
   a. The screening test is failed if the patient fails to hear any one tone in either ear.
   b. For screening purposes, middle ear pressure determination and the presence of absence of the acoustic reflex are the only factors involved in the referral criteria.
   c. Individuals having middle ear pressure outside the range of +100 to –200 mm pressure or who disclose a no peak tracing with no demonstrable acoustic reflex fails the screening. [11]

A rescreening test should be administered in two weeks for the student, and if the student fails the second screening, he/she should be referred for proper follow-up.

Audiometer Screening Pointers

1. One of the purposes of the screening test is to conserve time. If for any reason, the tester is unable to obtain a rapid test on a child, the child can be temporarily failed and retested at a later time.
2. With the exception described for obtaining an initial response, the tester should present tones only at the screening levels. To present tones at other levels is a waste of time.
3. The tester should never dismiss a child who has been totally unsuccessful in hearing the test tones. However, do not go higher than 50dB.
4. The tester should not let the child see him operate the tone level switch.
5. The tester should not look up each time he presents the tone
6. The tester should be sure that he indicates that a response was correct only after the response was made. As a general rule, it is better not to indicate that a response was correct or incorrect to the child.
7. The tester should not require the child to raise the hand that corresponds to the ear in which he/she hears the tone.
8. The success of the screening test depends largely on the skills of the tester, the adequacy of the testing area, and the function of the audiometric equipment. If the tester has doubts concerning the function of the equipment, he should contact the Commission's Hearing Conservation Representative.

Statistics

Statistics are maintained by the school district regarding how many children were screened (Exhibit 3O), how many needed further observation (Exhibit 3P) and also how many children were referred for follow-up (Exhibit 3Q and Exhibit 3R). These records are destroyed at the end of the school year.

Send statistics to your Hearing Conservation Representative by the end of the calendar year (semi-annual report) and then again at the end of the school year (annual report). If you are unsure who your Hearing Conservation Representative is, contact the Commission Office in your area or contact the Speech and Hearing Administrator in the Louisville office.

Vision Screening

According to 704 KAR 4:020(2)(11), the Board of Education shall adopt a program of continuous health supervision that includes scheduled screening tests for vision. *Note: There is no mandated grade that vision screening must occur. The districts may use their own discretion as to when screenings should be scheduled.* If history suggests it, more frequent screening should be done for that individual child.

Visual acuity has particular educational significance because of the obvious relationship to learning. Screening for distance is considered by authorities to be the single most important test of visual ability. Vision is most commonly described in acuity measure, or the best a child can see. 20/20 is considered normal vision.

Vision can be hampered in a number of ways. When a young child has a refractive error that is different between the right and left eye, the child's brain will ignore the weaker eye and only "see" the image from the stronger eye. As a result the child will not have binocular vision. An adult may see two images, or double vision, but a child who is learning to use vision will begin to see only the better image. This can develop into a condition known as AMBYLYOPIA- where both eyes are healthy but the brain uses only the information from the good eye and the other becomes "nonfunctional", commonly known as a "lazy eye." This condition can be corrected with glasses, surgery, and/or patching the "good eye". If this discrepancy is not corrected by the age of 6 years, the child may have permanent vision loss in the weaker eye.

Strabismus is caused by muscle balance problems, commonly described as "crossed eyes." The imbalance of the muscles causes the eyes to present two different images to the brain. The brain cannot process two different images so only one image from the stronger eye is accepted. Amblyopia can occur from strabismus or from an unbalanced refractive error (as described above). In some cases, glasses or patching may improve the weakened muscle balance, and in other cases surgery will be necessary. When the eyes are able to work together to produce one image, this is called binocular vision. Binocular vision is necessary for depth perception when judging the size and distance. It is an important factor in mobility.

Besides refractive errors and strabismus, injuries and various other physical conditions such as cataracts, glaucoma, and detached retinas can create difficulty in seeing.

Symptoms of vision difficulty may include:

1. Appearance: Crossed eyed, red eyes, watery eyes, crusty eyelids, frequent styes, and cloudiness in or around the pupil.
2. Behavior: Holds body rigid while looking at distant object, thrusts head forward or backward while looking at distant objects, avoids close work, has short attention span, turns head to use only one eye, tilts head to one side, places head close to book or desk when reading or writing, blinks excessively, rubs eye often, squints, and closes or covers one eye.
3. Complaints: headaches, nausea or dizziness, burning or itching of eyes, has blurry vision when looking up from close work, sees objects double, and undue sensitivity to light.

Treatment for visual problems may include:

1. Prescription for glasses or contact lenses;
2. Patching eyes and/or exercises;
3. Surgery for severe muscle imbalance, cataracts, or severe glaucoma;
4. Medication for infections, allergies, glaucoma, and other condition; and
5. Educational assistance for the visually impaired and legally blind (this may include visual aids and special classes or schools). [11]

Procedures For Assessing Vision

Ages Three to Adult:
Vision acuity is assessed in the school age child, adolescent and adult by the Snellen alphabet chart or instrument vision tester. Follow the same procedure for testing both eyes, then the right eye and the left eye, occluding the eye not being tested. Begin testing with the line above the referral line and test down to the appropriate line if possible. If the patient wears glasses, test with and without glasses.

Visual Acuity: Snellen "E" Chart or instrument vision tester, i.e. OPTEC 2000/Titmis, etc.

Supplies you will need for the Snellen Test:

1. Snellen "E" Chart
2. Window card
3. Tape measure
4. Adequate lighting
5. Large symbol "E"
6. Individual eye covers (may be made with construction paper cut with rounded corners or cone paper cups) to prevent the spread of infections.

Prepare the Screening Area

1. Select location that is quiet and free from distractions
2. Select location that has light colored wall that has no glare or shadows.
3. Attach Snellen "E" chart to wall so that the patient's eye level is on the 20-foot line.
4. Light intensity on chart should be 10-20 foot candles evenly diffused over chart.
5. Cover upper and lower portion of the chart with cover cards.
6. Mark exactly 20 feet of distance from chart.

Prepare the Child

1. Show the child the large letter "E" so he/she is familiar with the symbol.
2. A game can be made with teaching the child to point in the direction the "table legs of the "E" are pointed so he/she will understand the various positions of the "E".
3. Place child in standing position at the 20-foot mark and facing the chart. A set of footprints affixed to the floor with the heels at the 20-foot mark may help the child keep the proper position.
4. Teach the child to keep both eyes open during the test (when covering either eye).

Procedure

1. Test both eyes first, then the right eye and the left eye.
2. If patient wears glasses, test with and without glasses.
3. In testing one eye, occlude with other eye with an occluder or cone cup.
4. Begin on the 50-foot line of the Snellen "E" Chart for 3, 4 and 5 year olds. If that line is read correctly, got to the 40-foot line.
5. Begin on the 40-foot line of the Snellen "E: Chart for all patients above 6 years of age. If that line is read correctly, go to the 30-foot line.
6. With upper and lower portions of the chart covered, use window card to expose one symbol at a time.
7. Move window card promptly and rhythmically from one symbol to another at the speed with which the patient seems to keep pace.
8. In linear testing, it may be necessary to use a pointer to indicate the letter.
9. Patient points with him arm or hand in the direction the legs of the "E" point.
10. To pass a line the patient must see one-half, or more than half of the symbols on that line.

11. Observe for signs of eye problems, i.e. tilting the head, peeking around the occluder.
12. Record visual acuity (the last successful line read in the order tested…both eyes-right eye and left eye.

Record the results as a fraction – e.g. 20/30, 20/40, etc. The numerator represents the distance from the chart; the denominator represents the last line read. A reading of 20/50, for example, indicates that the child read at 20-feet the line that should be read at a distance of 50-feet. When using an instrument vision tester, follow manufacturer's direction for vision assessment. Record results of class vision screening on Class Vision Flow Sheet (Exhibit 3S).

Snellen Test Referral Criteria For Ages 6-Adult

The larger the denominator is, the poorer the vision. If vision is poorer than 20/30, refer the person to an ophthalmologist or optometrist. (Exhibit 3T) Results of the vision screening should be recorded on the individual health record (Cumulative Health Record, Exhibit 3I).

Height, Weight and Body Mass Index

The purpose of a height and weight screening is to identify children who are experiencing or may be at risk for abnormal growth patterns for their age, weight, and/or heredity. [11]

Law does not mandate screening height and weight; however, your district may set policy requiring height and weight screening on a regular basis. The Kentucky Department of Education suggests that height and weight should be measured annually in the preschool and elementary grades and at least one (1) time during the middle school grades and one (1) time in high school.
(See Health Matrix, Exhibit 3A)

The Centers for Disease Control and Prevention (CDC) recommends calculating BMI to determine if children are overweight. BMI (weight (kg) divided by stature (cm) X 10,000; or weight (lb) divided by stature (in) X 703) is calculated from height and weight measurements and is used to judge whether an individual's weight is appropriate for their height. The BMI-for-age charts are recommended to assess weight in relation to stature for children ages 2-20 years. The weight-for-stature charts are available as an alternative to accommodate children 2-5 years who are not evaluated beyond the preschool years (CDC, 2003)

Weight and height are sensitive issues and body image greatly influences self-esteem. Therefore, assuring privacy during screening should be attained whenever possible. Height and weight screenings should be based, not on the comparison of one student with another, but the comparison should be for each student's personal growth record. (See Exhibit 3U-Class Height Weight List) Record screening results for each student in his/her Cumulative Health Record.

The following guidelines for "height, weight, and body mass index screening process" are excerpted from Kentucky Department for Public Health's (2003) Public Health Practice Reference: [13]

Height, Weight & Body Mass Index Screening Process

Height:

Obtain a standing height on children greater than 2 to 3 years of age, adolescents, and adults. Measurements may be accurately made by using a graduated ruler or tape attached to the wall and a flat surface that is placed horizontally on top of the head. The patient is to be wearing only socks or bare foot. The knees are to be straight and feet flat on the floor, and the patient is asked to look straight ahead. The flat surface (or moveable headboard) is lowered until it touches the crown of the head, compressing the hair. A measuring rod attached to a weight scale shall not be used.

If recumbent length is obtained for a two year old, it is plotted on the birth to 36 months growth chart, whereas, if standing height is obtained for a two year old, plot on the 2 to 18 year growth chart. Plot measurements for children on age and gender specific growth charts and evaluate accordingly.

Weight:

Balance beam or digital scales are to be used to weigh patients of all ages. Spring type scales are not acceptable. CDC recommends that all scales should be zero balanced and calibrated. Scales must be checked for accuracy on an annual basis and calibrated in accordance with manufacturer's instructions. Prior to obtaining weight measurements, make sure the scale is "zeroed". Weigh infants wearing only a dry diaper or light undergarments. Weigh children after removing outer clothing and shoes. Weigh adolescents and adults with the patient wearing minimal clothing. Place the patient in the middle of the scale. Read the measurement and record results immediately. Scales should be calibrated annually. Record individual height and weight on the Class Height and Weight Form (Exhibit 3U). Plot measurements on age and gender specific growth charts (Exhibits 3V, 3W, 3X or 3Y).

Body Mass Index:

The Body Mass Index (BMI) is a measure that can help determine if a person is at risk for a weight-related illness. The amount of body fat in children changes with age. Girls and boys body fatness will differ as they mature. The BMI is specific for age and plotted on a gender specific graft. More information on BMI for children may be found on the CDC website at:
http://www.cdc.gov/nccdphp/dnpa/bmi/bmi-for-age.htm [14]

BMI for Age Categories

- Underweight = less than 5th percentile
- Normal weight = 85th percentile to less than 95th percentile
- Overweight = greater than 95th percentile

PUPIL'S CUMULATIVE HEALTH RECORD

JANUARY 1993

Name _____ Date of Birth _____ Physical Examination(s) _____

(*Last* *(First)* *(Middle)*

Health conditions such as severe allergies, disabilities, chronic illness, or other special health needs (Add comments on back.) _____

_____

504/IEP Date of Review or Reevaluation _____

Screening Record

Record date of screening and student's age with each screening result. *Indicate with an asterisk if student is wearing glasses during vision screening.

DATE									
Height									
Weight									
Vision: Right Eye									
Left Eye									
Hearing: Right Ear									
Left Ear									
Scoliosis									
Other Screening:									

DOCUMENTATION

Use this side to record referrals and follow-ups *(physician, clinic, parent, etc.)*, special procedures required during the school day, or other significant findings that may affect the student's school participation. Please sign and date all entries.

PUPIL'S CUMULATIVE HEALTH RECORD

The purpose of this record is to give the health professional a concise summary of the student's school health history. It is not intended to be used for daily documentation. Parent and emergency information should be maintained elsewhere.

Screenings are recorded by date and student age rather than grade level. This accommodates changes in the primary program and documents the information more accurately for the student.

The reverse side of the form is designed to allow school personnel ample space to document other information pertinent to the school health program.

SCHOOL SCREENING FOR SCOLIOSIS

Screening Procedure Worksheet

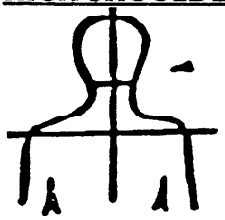
SIDE VIEW

Upper back Normally Rounded, Neck Erect, Chin In, Head in Balance

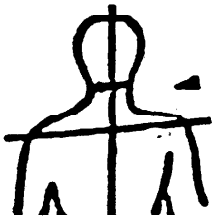
Upper back Slightly More Rounded, Neck Slightly Forward, Chin Slightly Out

Upper back Markedly Rounded, Neck Markedly Forward, Chin Markedly Out

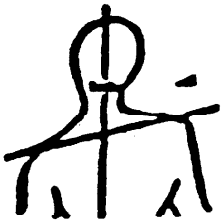
HIGH SHOULDER



Shoulders Level (Horizontally)

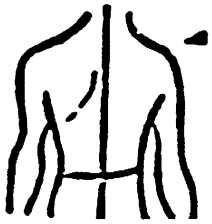


One Shoulder Slightly Higher Than Other

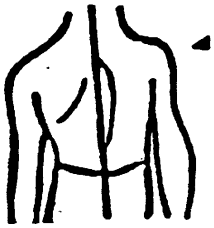


One Shoulder Markedly Higher Than Other

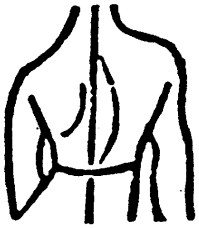
CURVED SPINE



Spine Straight

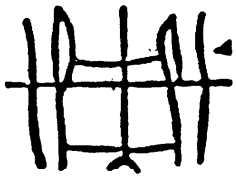


Spine Slightly Curved Laterally

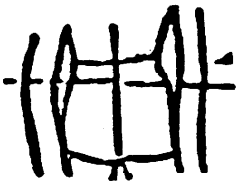


Spine Markedly Curved Laterally

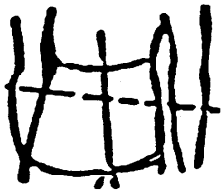
HIGH HIP



Hips Level (Horizontally)



One Hip Slightly Higher



One Hip Markedly Higher

LUMBAR PROMINENCE RIB HUMP

Normal Symmetrical

Abnormal Asymmetrical

Normal Symmetrical

Abnormal

Source: Kentucky Commission for Handicapped Children, Louisville, KY,

PARENTAL PERMISSION FORM FOR SCOLIOSIS SCREENING

Dear Parent(s) or Legal Guardian(s):

In recent years, you may have seen an ever-increasing number of teenage girls and boys wearing neck and back braces. You may have assumed these were the result of auto accidents – but in reality, most of the children were being treated for scoliosis. Simply stated, scoliosis is an S-shaped curvature of the spine. In its early years it is painless and appears gradually, especially during the years of rapid teenage growth. It is often confused with poor posture.

Some cases of scoliosis are so mild as to need no medical attention at all. Others get progressively more severe as the child grows. If detected in its early stages during the growth years, exercises or a brace like those you have seen may be all that is needed to prevent further curvature. Unfortunately, if not detected and treated early, the curvature can become great enough to severely affect a person's appearance and health.

704 KAR 4:020 "School Health Services" directs that a Scoliosis Screening Program be adopted in our schools. Scoliosis screenings are to be held in grades 6 and 8 and will be conducted by nurse(s) or trained staff or volunteers during the school day. The procedure for screening is simple; the screener looks at the child's back, standing and bent forward. Female students should wear a halter top under regular clothes, swim suit or sports bra. Male students should be prepared to remove their shirt.

A nurse will re-screen those students referred and, if further examination is indicated, you will be notified and requested to take your child to your local health care provider for further examination and x-ray.

Please sign the permission form below and return it to the school as soon as possible. (If your child is currently under treatment for a back problem, he/she does not need to participate in this screening program.)

Sincerely,

_____

Screening Date: _____ Grade Level: _____

PERMISSION FORM

[Please check one]: ( ) I Do ( ) I Do Not want my child to participate in the School Scoliosis Screening Program for detecting a possible curvature of the spine.

Name of Student: _____

Signature of Parent of Legal Guardian: _____

Source: KY Dept of Education

SCOLIOSIS SCREENING WORKSHEET

School: _____ Grade: _____

Screener: _____ Date: _____

Code: P=Passed R=Referred

Name of Student	Age	Sex	Absent	1st Screening		2nd Screening		Comments
				P	R	P	R	

Note: This document shall be shredded at the end of each school year.

Source: KY Dept of Education

SCOLIOSIS SCREENING MASTER LIST

School: _____ Screener: _____

County: _____ Grades: _____

Date screened: _____ Number screened: _____

Number of Denied Permissions: _____

Number Referred for Second Screening: _____

Number Referred From Second Screening to M.D. : _____

List Referrals Below:

Name	**Sex**	**Disposition (Screen next year or M.D. referral)**

Source: KY Dept of Education

REFERRAL LETTER FOR SCOLIOSIS SCREENING

Date: _____ School: _____

Student: _____ Birthdate: _____

Parent/Guardian: _____

Address: _____

_____

Zip code: _____ Telephone: _____

Dear Health Care Provider:

During our school-screening program, the following abnormal physical findings were noted on this child: (Please be specific but brief) _____

_____

_____

Please schedule this child for evaluation as soon as possible.
Follow-up information from you is necessary for us to fully evaluate this screening program.
We request that you complete the section below and return this form to:

_____

Thank you for your cooperation. If you have any questions, please feel free to call _____.

For Health Care Provider's Use Only

X-Ray Results: _____

_____

( ) No significant findings at this time: _____

( ) Need for further evaluation: _____

( ) Re-examination or treatment recommended on (date): _____

( ) Additional Comments: _____

_____

Date of Exam: _____

Signed: _____, M.D.

Address: _____

Zip Code: _____ Telephone: _____

Source: KY Dept of Education

HEARING SCREENING CLASS LIST

School: _____ Grade: _____

Teacher: _____ Date: _____

Instructions: List all children in the class. The information on this list should be recorded on each pupil's Cumulative Health Record.

After each child's name, place a check (√) in the Pass column if he/she passes the hearing screening or an (X) in the Fail column if he/she fails the screening.

If the child passes the second screening test, place a check (√) in the Pass column and draw a double line through the initial (X). If he/she fails the second screening test, place a second (X) in the Fail column.

Name of Student	Pass	Fail	Name of Student	Pass	Fail

Source: KY Dept of Education

HEARING SCREENING - FURTHER OBSERVATION LIST

Audiometer Used: _____ Calibration ANSI Tympanometer Used: _____

Name	Remarks	Grade	Test Results								Tymp: Results	Audio Ref.	Medical Ref.
			Right				Left						
				1000	2000	4000		1000	2000	4000			

Source: KY Dept of Education

HEARING SCREENING REFERRAL

Student: _____ Age: ____ Sex: _____

Parent/Guardian: _____

Address: _____

_____

School: _____ Grade: _____ Teacher: _____

Dear Parent or Guardian:

We have completed the hearing screening service provided as part of the School Health Program. Results of your child's hearing test indicate the need for a more complete hearing examination.

Since uncorrected hearing disorders can affect learning potential, it is important to complete this referral and return it to the school when completed.

Thank you for your cooperation. If you have any questions or if I can be of service, please contact me. _____,
School Nurse/ School Health Coordinator. Phone: _____.

Please return to:

_____

_____

_____

Hearing Test Results (non-clinical testing area)

Frequency		1000	2000	4000		Remarks
Right Ear						
Left Ear						

Treatment: _____ Return advised? _____ When? _____
Health Care Provider: _____ Date: _____
Address: _____

_____

Source: KY Dept of Education

COMMISSION FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS

Re: School _____

Date _____

County _____

Dear Parent:

Your child _____, recently received a hearing screening. The results indicate the need for further evaluation.

It is recommended that your child be seen by a physician for an ear examination. You may wish to consult with an otologist. In any case, please take this letter to the physician who examines your child.

If you are unable to afford private care for your child, please contact your local health department of call 1-800-232-1160 for more information regarding the Commission for Children With Special Health Care Needs program in your area.

Sincerely,

_____

Physician's Report:

Child's Name _____ BD _____Date _____

Physician's Findings: _____

Treatment Given: _____

Recommendations: _____

Please return form to:

_____

_____

_____

Parent: I agree to release the above information on my child or ward.

_____ _____

Parent or Guardian's Signature Physician's Signature

Source: KY Dept of Education

CLASS VISION FLOW SHEET

Name	Both	Right	Left	Without glasses (W/O) With glasses (W)	Referral Yes/No	Date Report received	Follow-up Indicated

Source: KY Dept of Education

VISION SCREENING REFERRAL

Student: _____ Age: ____ Sex: _____

Parent/Guardian: _____

Address: _____

_____

School: _____ Grade: _____ Teacher: _____

Dear Parent or Guardian:

We have completed the vision screening service provided as part of the School Health Program. Results of your child's vision screen indicate the need for a more complete eye examination.

Since uncorrected vision disorders can affect learning potential, it is important to complete this referral and return it to the school when completed.

Thank you for your cooperation. If you have any questions or if I can be of service, please contact me. _____,
School Nurse/ School Health Coordinator. Phone: _____.

Please return to:

_____

_____

_____

Examination Results

___ Normal Exam
___ Amblyobia ____ Muscle Imbalance ____ Refractive Error Other _____
___ Myopia
___ Hyperopia
___ Astigmatism

Treatment: _____ Return advised? _____ When? _____
Health Care Provider: _____ Date: _____
Address: _____
_____

Source: KY Dept of Education

CLASS HEIGHT / WEIGHT

Month ___ Year ____ Page ____ of _____

Name	Height	Weight	BMI	Age	Referral Yes/No	Follow-up Indicated	Absent

Source: KY Dept of Education

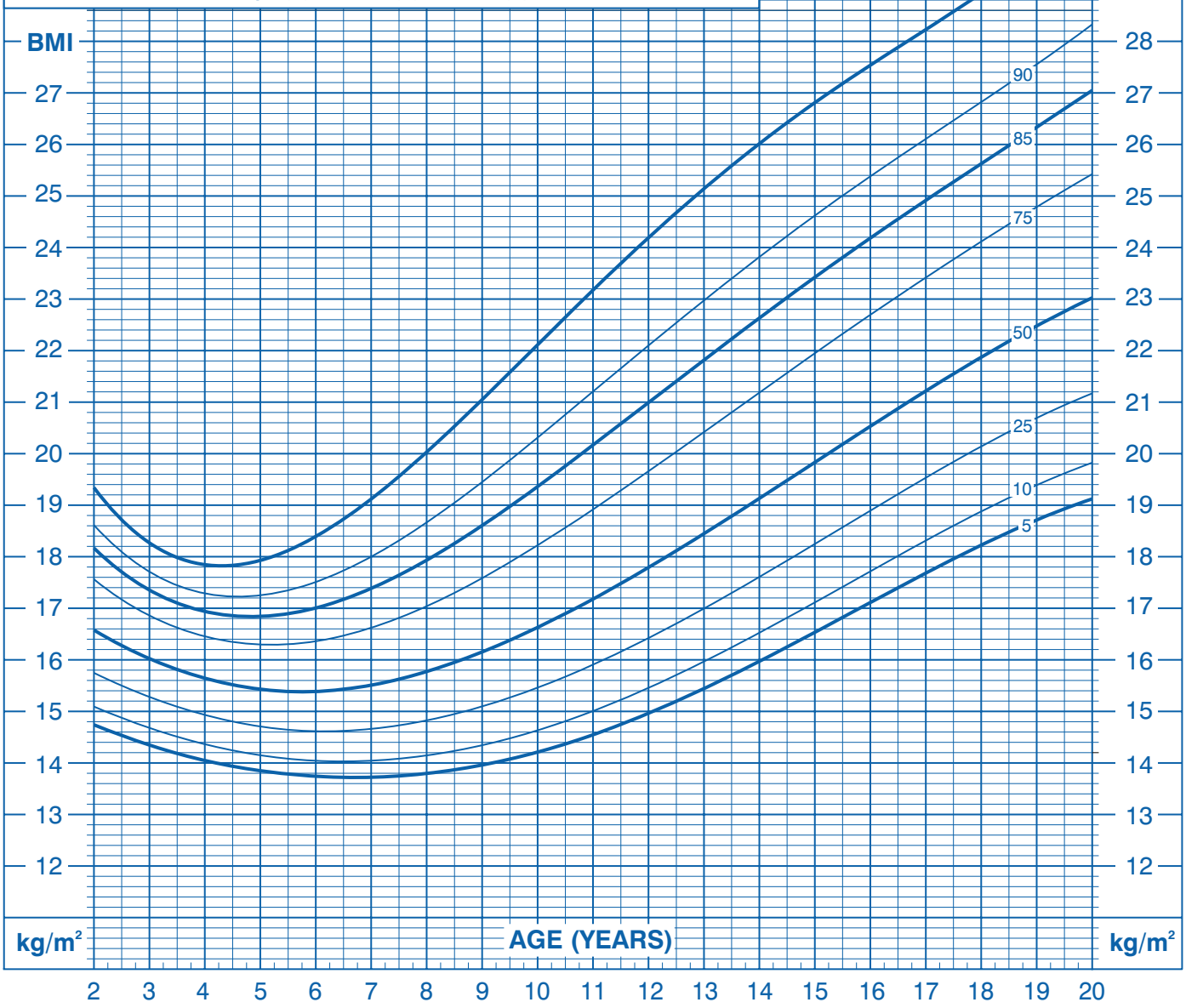
2 to 20 years: Boys
Body mass index-for-age percentiles

NAME _____

RECORD # _____

Date	Age	Weight	Stature	BMI*	Comments

***To Calculate BMI**: Weight (kg) ÷ Stature (cm) ÷ Stature (cm) x 10,000
or Weight (lb) ÷ Stature (in) ÷ Stature (in) x 703



Published May 30, 2000 (modified 10/16/00).

SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
http://www.cdc.gov/growthcharts

CDC
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2 to 20 years: Boys
Stature-for-age and Weight-for-age percentiles

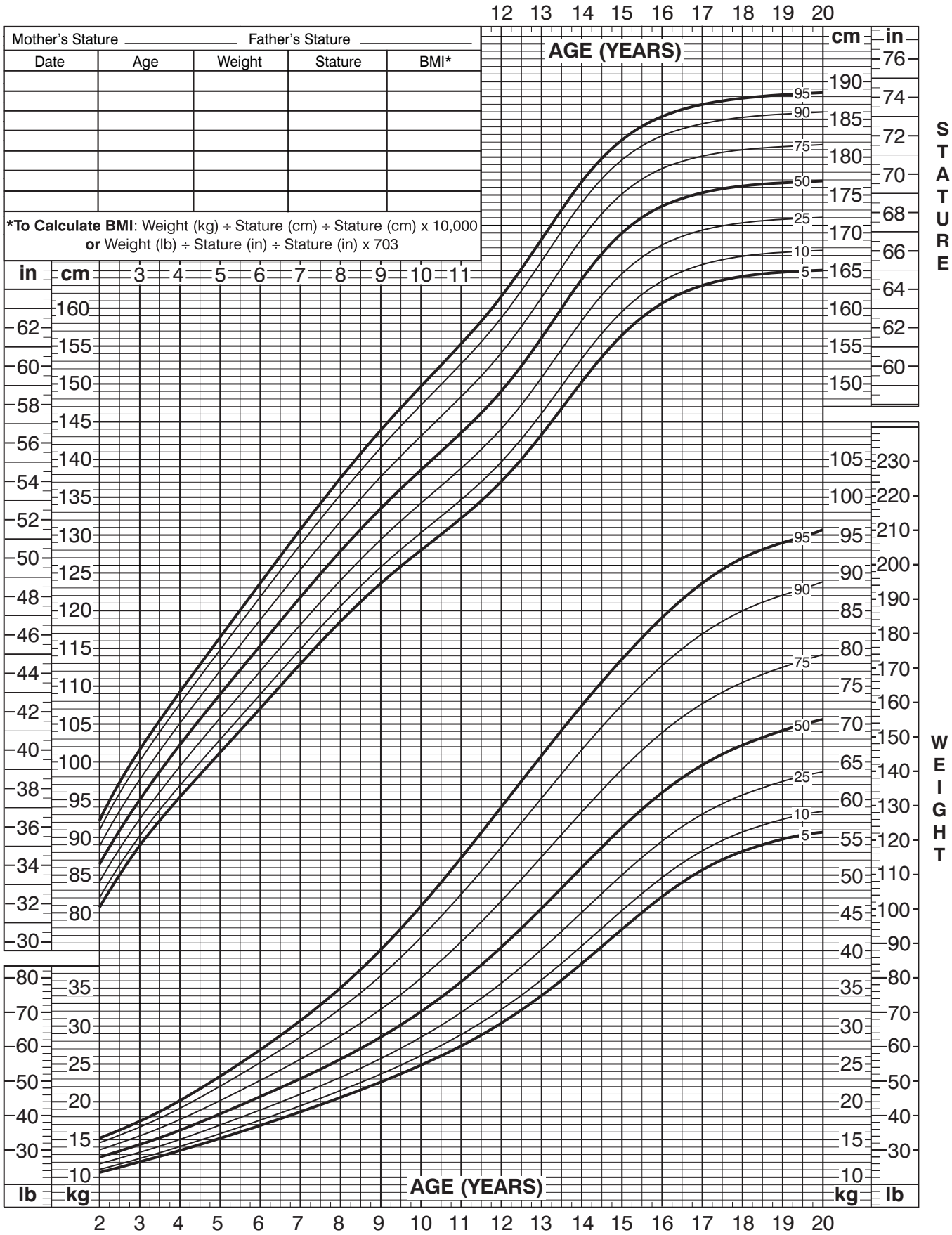
NAME _____

RECORD # _____

Mother's Stature _____ Father's Stature _____

Date	Age	Weight	Stature	BMI*

***To Calculate BMI**: Weight (kg) ÷ Stature (cm) ÷ Stature (cm) x 10,000
or Weight (lb) ÷ Stature (in) ÷ Stature (in) x 703



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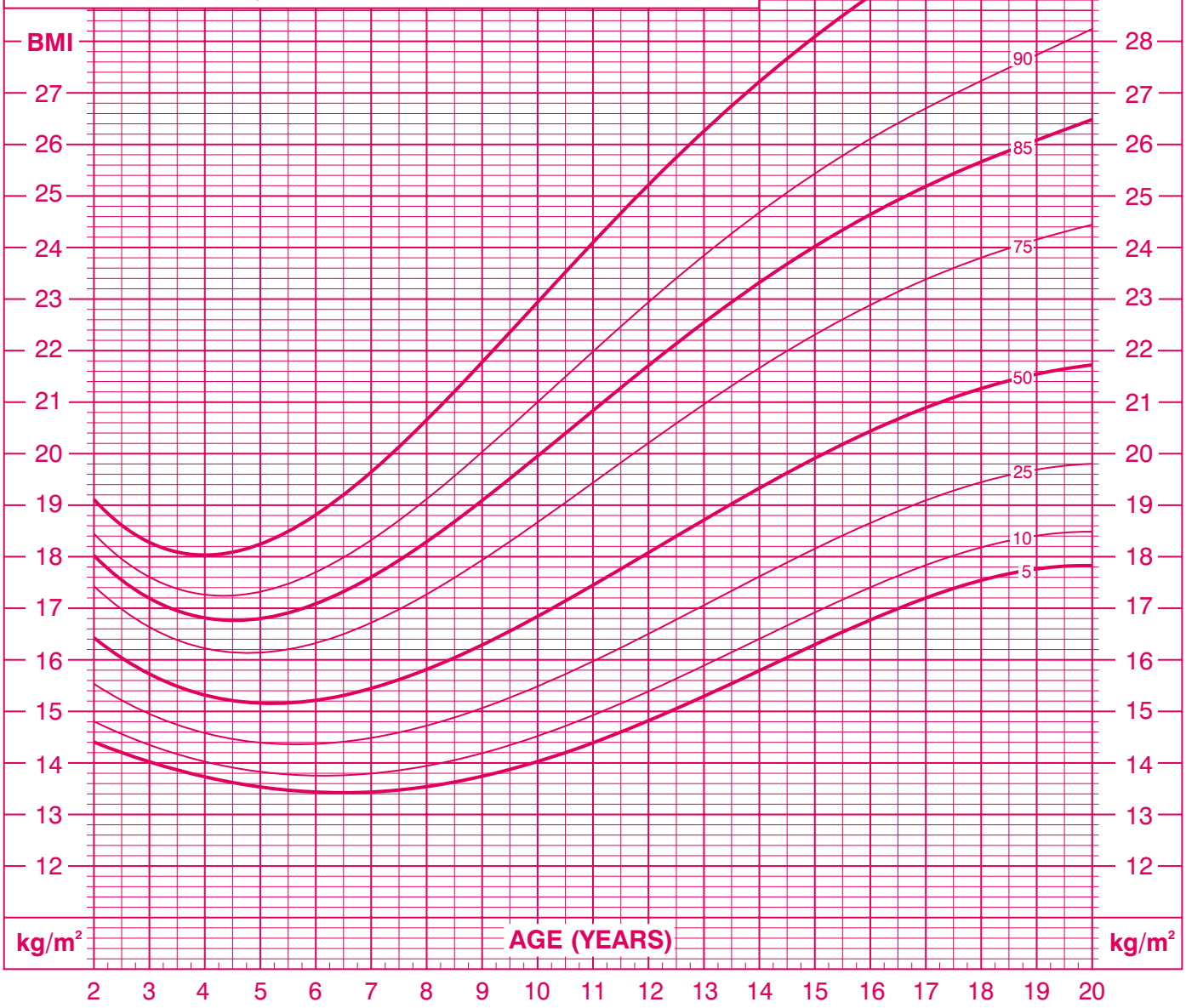
2 to 20 years: Girls
Body mass index-for-age percentiles

NAME _____

RECORD # _____

Date	Age	Weight	Stature	BMI*	Comments

***To Calculate BMI**: Weight (kg) ÷ Stature (cm) ÷ Stature (cm) x 10,000
or Weight (lb) ÷ Stature (in) ÷ Stature (in) x 703



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2 to 20 years: Girls
Stature-for-age and Weight-for-age percentiles

NAME _____

RECORD # _____

Mother's Stature _____ Father's Stature _____

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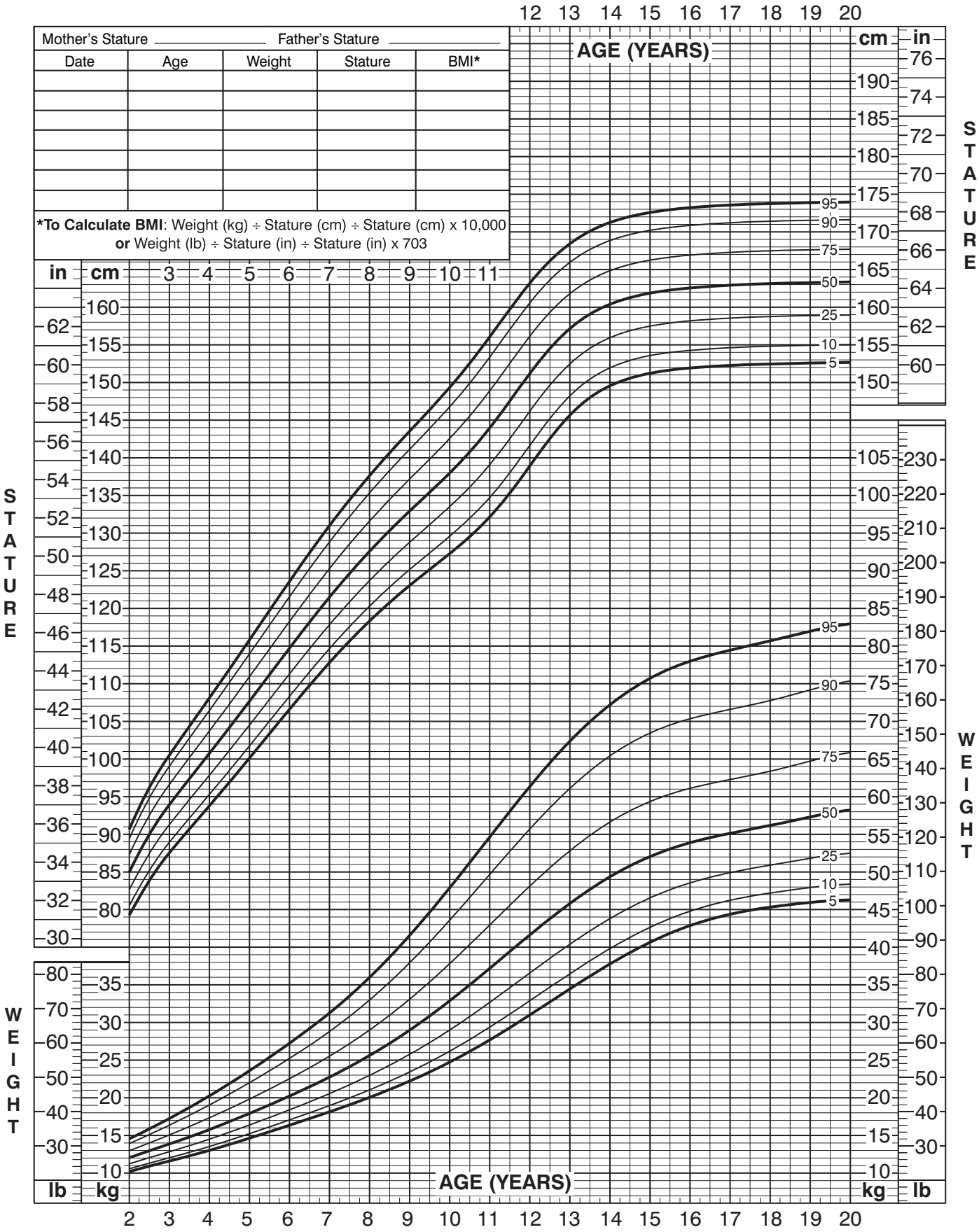
or Weight (lb) ÷ Stature (in) ÷ Stature (in) x 703



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