Spinal Screening Report

Name of School/District:_____
City: _____ County: _____
Contact: Name/title/phone/email: _____

Enter the total number of students in each category for each grade:

Grade	Under prior treatment (no screening)	Screened	Rescreened	Referral
5M				
5F				
6M				
6F				
7M				
7F				
8M				
8F				
9M				
9F				
Totals				

Submit this form to the Utah Department of Health, School Nurse Consultant by facsimile at 801.538.9440. Forms must be submitted by June 15th of each school year.

_____ Date: _____
School/District Nurse