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| **POSTURAL SCREENING WORKSHEET** | Under Current Medical Treatment |
| School: | postural screening | Y/N | Refer for Reason Date |
| Address | Y/N | Rescreening Screener: | Date: |  |
| Screener: |  | P.E. R.N | Confirm Findings Y/N | Follow Up |
| Grade: Class Size: Date: |
| Student Name | Sex | DOB | Date Family Contacted | Date Referred to Physician | Physician's Diagnosis & Treatment Report Done | Needs School Follow Up |
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|  | From: *Training Material Postural Screening Program.* 1996. Massachusetts Department of Public Health. Downloaded 11/28/2016 from<http://www.mass.gov/eohhs/docs/dph/com-health/school/psmanual04.pdf> |