Age EI/ECSE VISION SCREENING QUESTIONNAIRE

Please complete this form in its entirety.

Name:____ **DOB:**____________________

1. Does the parent have concerns about the child's vision? Describe:
2. Is there a known syndrome or medical diagnosis? Describe:
3. Was the child premature?
4. Has the child seen an eye care specialist? Physician Name: Results:
5. Does the child wear glasses?
6. Does the child have his/her eye patched anytime during the day?
7. Are there unusual eye movements? Describe:
8. Does either eye turn in or out?
9. Does the child lack a blink response?
10. Does the child have an unusual response to light?
11. Does the child fail to look toward the object he/she is reaching for?
12. Does the child over or under reach for objects?
13. Does the child rub or poke his/her eyes?
14. Do the eyes water frequently?
15. Are there unusual head positions?
16. Does the child have difficulty recognizing familiar adults/objects across the room?
17. Does the child appear to be awkward, clumsy, run into doors, walls, or have difficulty with a variety of surfaces?
18. Does the child appear hesitant to move in unfamiliar environments?

Additional Comments:

Form completed by:____ Date:_________________________

After completing this checklist, if any questions are answered in the positive, please take this form to the IFSP team to determine if there should be referral to a health care practitioner or an ophthalmologist or an optometrist.

Vision Screening Guidelines