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

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