Vision Symptom Questionnaire

Adapted from Utah Department of Health & Human Services in accordance with UCA 53G-9-404 and R384-201

Student name:	Date:
School:	Grade:
Teacher:	
Name and title of person completing the form:	
Does the student wear glasses? ☐ Yes ☐ No	

Teachers must complete this questionnaire for:

- Students in grade 1-3 who do not meet benchmark on the reading assessment.
- Students undergoing a special education evaluation or reevaluation for a suspected disability that may be affected by vision difficulties.
- Any student for whom a parent or teacher has a concern about vision.

Once completed, please **submit the questionnaire to the school nurse** for review.

Reason for form completion:

☐ Failure to achieve benchmark (grades 1-3, teacher should complete form)

☐ Special education referral or re-evaluation (any grade, teacher should complete form)

☐ Teacher concern (any grade, teacher should complete form)

☐ Parent concern (any grade, parent should complete form)

General symptoms, if yes please comment	Yes	No	Comments
1. As a teacher or parent are you concerned with this student's vision?	☐	☐	
Appearance symptoms	**Yes**	**No**	**Comments**
2. Tilts head, squints, closes or covers one eye when reading	☐	☐	
3. Gaze issues, eyes turn in or out, crossed eyes, eyes wander	☐	☐	
4. Different size pupils or eyes	☐	☐	
5. Watery eyes, eyes appear hazy or clouded	☐	☐	
Behavior symptoms	**Yes**	**No**	**Comments**
6. Loses place when reading	☐	☐	
7. Skips over or leaves out small words when reading	☐	☐	
8. Writes uphill or downhill; difficulty writing in a straight line	☐	☐	
9. Has difficulty copying from the board	☐	☐	
10. Avoids near work, such as reading or writing	☐	☐	
11. Has difficulty lining up numbers when doing math	☐	☐	
12. Holds books too close; leans too close to a computer screen	☐	☐	
13. Clumsy; bumps into things; knocks things over	☐	☐	
Complaint (from the student) symptoms	**Yes**	**No**	**Comments**
14. Words float, move, or jump around when reading	☐	☐	
15. Complains of headaches, dizziness, or nausea when reading (please specify)	☐	☐	
16. Complains of itching, burning, or scratchy eyes (please specify)	☐	☐	
17. Complains of blurred or double vision, unusual sensitivity to light, or difficulty seeing (please specify):	☐	☐	
18. History of head injury with vision complaints	☐	☐	
19. Other vision concerns:			

Student name:	Date:

For school nurse use only:

Any parent or teacher vision concern or "Yes" response on the questionnaire should be reviewed by the school nurse. The school nurse will use professional judgment, considering the questionnaire responses and other relevant information, to determine whether a Tier 2 vision screening, referral to an eye care professional, or other follow-up is appropriate.

The school nurse may recommend additional screening or referral regardless of the questionnaire responses when professional judgment indicates further evaluation is warranted.

Required: Tier one distance vision screened ☐ Pass ☐ Refer	Required: Near vision screened ☐ Pass ☐ Refer
Eye focusing or tracking screened? ☐ Yes ☐ No ☐ Pass ☐ Refer	Convergence screened? ☐ Yes ☐ No ☐ Pass ☐ Refer
Hearing screened? ☐ Yes ☐ No ☐ Pass ☐ Refer	Color vision screened? ☐ Yes ☐ No ☐ Pass ☐ Refer
Please note: if the student does not pass their initial hearing screening, they should be rescreened in 2-3 weeks.	
Referred to an eye care professional: ☐ Yes ☐ No	Date:
Referred to a healthcare professional: ☐ Yes ☐ No	Date:
Notes:	
School nurse name:	
School nurse signature:	Date: