



## Vision Symptoms Questionnaire

*Adapted from Utah Department of Health in accordance with UCA 53G-9-404*

Student Name				Referral Date	
School		Grade		Teacher	
Name and Title of Person Completing the Form					
Does the student wear glasses?		<input type="checkbox"/> yes <input type="checkbox"/> no			
Teachers are required to complete this form if a student is being referred for special education services related to a specific learning disability, emotional disturbance, or multiple disabilities. Parents may also complete this form if there is a vision concern. <b>If answer is 'yes' to any areas below, please provide additional information in the comment section(s).</b>					
		Yes	No	Additional Comments	
As a teacher or parent are you concerned with this student's vision?					
<b>Appearance Symptoms</b>					
Tilts head, squints, closes or covers one eye when reading					
Gaze issues, eyes turn in or out, crossed eyes, eyes wander					
Different size pupils or eyes					
Watery eyes, eyes appear hazy or clouded					
<b>Complaints (Student Statements) Symptoms</b> <i>(please specify student complaints in comments section)</i>					
Words float, move, or jump around when reading					
Complains of headaches, dizziness, or nausea when reading					
Complains of itching, burning, or scratchy eyes					
Complains of blurred or double vision, unusual sensitivity to light, or difficulty seeing					
<b>Behavior Symptoms</b>					
Loses place when reading					
Skips over or leaves out small words when reading					
Writes uphill or downhill; difficulty writing in a straight line					
Has difficulty copying from the board					
Avoids near work, such as reading and writing					
Has difficulty lining up numbers when doing math					
Has difficulty finishing assignments on time					
Holds books too close; leans too close to a computer screen					
Clumsy; bumps into things; knocks things over					

*When complete, please give this form to the school nurse for tier 2 evaluation and possible referral to an eye care professional.*



**FOR SCHOOL NURSE USE ONLY**

- Any parent or teacher concern and/or any 'yes' answers should be evaluated by the school nurse to determine if tier 2 screening or referral to an eye care professional is necessary.
- School nurse should use their professional nursing judgment in determining whether the student receives a tier 2 vision screening and/or is referred to an eye care professional, regardless of the answers.

Distance Vision Screened	<input type="checkbox"/> pass	<input type="checkbox"/> fail		
Near Vision Screened	<input type="checkbox"/> pass	<input type="checkbox"/> fail		
Saccades & Pursuits Screened	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes: <input type="checkbox"/> pass	<input type="checkbox"/> fail
Convergence Screened	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes: <input type="checkbox"/> pass	<input type="checkbox"/> fail
Color Vision Screened	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes: <input type="checkbox"/> pass	<input type="checkbox"/> fail
Referred to eye care professional	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date	
<b>Additional Notes</b>				
School Nurse Name:				
School Nurse Signature:				Date