Vision Survey for Families

The following survey assists in determining if your student requires additional vision evaluations. If concerns are noted, your student may have a vision screening completed, and/or a vision referral will be sent home. Regarding your student, please answer the following questions

	Yes	No
Has your student been evaluated for vision screening by a health care provider?		
Does your student currently wear glasses or contacts?		
Eye Appearance		
Eyes turn out/eyes are crossed		
Eyelid(s) are droopy		
Eyes are hazy or clouded		
Different sized pupils		
Eyes are: Red Crusty Swollen lids (circle those that apply)		
Behavior Observations		
Holds book close to face		
Sits up close when using the computer		
Uses finger as a guide on book when reading		
Blinks excessively while reading		
Feels things to assist with interpretation		
Makes errors when copying words from paper to paper/computer		
Complaints		
Eyes hurt or blur after reading for a short period of time		
Unable to see objects at a distance		
Headaches Dizziness Nausea (circle those that apply)		
Itching Burning Scratching (circle those that apply		
Additional Concerns:		

Student Name_____ Grade_____

Parent Signature_____ Date_____