Vision Symptoms Questionnaire

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

Teachers are required to complete this form if a student does not achieve benchmark on the benchmark reading assessment (grades 1-3) or is being referred for special education services related to a specific learning disability. Parent may also complete this form if there is a vision concern. When completed please give this form to the school nurse* for tier 2 evaluation and possible referral to an eye care professional. Student Name: Referral Date: Grade: School: Teacher: Name/Title of person completing form: Does student wear glasses? □ yes □ no If answer is 'yes' to any areas below, please Yes Nο Comments provide details in the comment section(s). 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 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 Complaints (Student Statements) Symptoms Yes No Comments 6. Words float, move, or jump around when reading 7. Complains of headaches, dizziness, or nausea when reading (please specify) 8. Complains of itching, burning, or scratchy eyes (please 9. Complains of blurred or double vision, unusual sensitivity to light, or difficulty seeing (please specify): 10. History of head injury with vision complaints **Behavior Symptoms** Yes No Comments 11. Loses place when reading 12. Skips over or leaves out small words when reading 13. Writes uphill or downhill; difficulty writing in a straight line 14. Has difficulty copying from the board 15. Avoids near work, such as reading or writing 16. Has difficulty lining up numbers when doing math 17. Has difficulty finishing assignments on time 18. Holds books too close; leans too close to a computer 19. Clumsy; bumps into things; knocks things over Other vision concerns:

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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 judgement 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: ☐ Pass ☐ Fail (refer)		Near vision screened: Pass Fail (refer)	
Eye Focusing or tracking screened? \square Yes \square No		Convergence screened? Yes No	
☐ Pass ☐ Fail (refer)		☐ Pass ☐ Fail (refer)	
Referred to eye care professional: ☐ Yes ☐ No			Date:
Notes:			
School Nurse Name:			
School Nurse Signature:			Date:
*For Schools without a School Nurse or other approved tier 2 vision screener:			
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