

SAMPLE

Parent/Teacher Vision Checklist

This tool is to help identify children who may have a problem with their eyes. Please check the appropriate items and return to the school nurse.

Name: _____ **Date:** _____

Apppearance

- ___ Eyes turn in or out or eyes are crossed
- ___ Crusty or red eyelids
- ___ Different size pupils or eyes
- ___ Swelling of eyelids
- ___ Conjunctivitis (pink eye)
- ___ Drooping lids
- ___ Excessive tearing
- ___ Eyes appear hazy or clouded
- ___ Other: _____

Behavior – Teacher Observation

- ___ Tilts head, covers or closes one eye for critical seeing
- ___ Thrusts head forwards, squints or frowns
- ___ Holds printed materials in an unusual position
- ___ Other: _____

Complaints – Child’s Statements

- ___ Eyes hurt or blur while reading/near work
- ___ Headaches, dizziness, or nausea following close work
- ___ Words move or jump about when reading/near work
- ___ Double vision
- ___ Unable to see the board
- ___ Eyes itching, burning or a “scratchy” feeling
- ___ Difficulty seeing near objects (may report a “blur”)
- ___ Other: _____

Please include any additional comments/concerns about academic progress.