Oregon Department of Education
Autism Spectrum Disorder
Vision Screening Checklist Interview

An interview format should be used with the parent to complete this checklist.
Please complete this form in its entirety

Student's Name: _____ Date of Birth: _____

Parent's name: _____ Interviewer: _____

Date Checklist Completed: _____

Question	Yes	NO	Not Sure
1. Do you have concerns about the child's vision? Describe:			
2. Is there a known syndrome or medical diagnosis? Describe:			
3. Has the child seen an eye care specialist? Name of eye care specialist:			
4. Was the child premature?			
5. Does the child wear glasses?			
6. Does the child have his/her eye patched anytime during the day?			
7. Are there any unusual eye movements?			
8. Does either eye turn in or out?			
9. Does the child lack a blink response?			
10. Does the child have an unusual response to light?			
11. Does the child fail to look toward the object he/she is reaching for?			
12. Does the child over or under reach for objects?			
13. Does the child rub or poke his/her eyes?			
14. Do the eyes water frequently?			
15. Are there any unusual head positions?			
16. Does the child have difficulty recognizing familiar adults/objects across the room?			
17. Does the child appear to be awkward, clumsy, runs into doors, walls or have difficulty with a variety of surfaces?			
18. Does the child appear hesitant to move in unfamiliar environments?			

Additional Comments: (use back of form)

Refer to OAR 581-021-0031 for more information