Name: Date of Birth:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Question** | **Yes** | **No** | Not Sure |
| 1. | Does the parent have concerns about the child’s vision?  Describe: |  |  |  |
| 2. | Is there a known syndrome or medical diagnosis?  Describe: |  |  |  |
| 3. | Was the child premature? |  |  |  |
| 4. | Has the child seen an eye care specialist?  Physician’s name:  Results: |  |  |  |
| 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?  Describe: |  |  |  |
| 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 difficultly recognizing familiar adults/objects across the room? |  |  |  |
| 17. | Does the child appear to be awkward, clumsy, run into doors, walls or have difficulty with a variety of surfaces? |  |  |  |
| 18. | Does the child appear hesitant to move in unfamiliar environments? |  |  |  |

Additional Comments:

Form completed by: Date:

*After completing this checklist, if any questions are answered in the positive, please take this form to the child’s team to determine if there should be a referral to a health care practitioner, an ophthalmologist or an optometrist.*