

## Vision Symptoms Questionnaire

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

<i>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.</i>			
Student Name:	Referral Date:		
School:	Grade:		
Teacher:			
Name/Title of person completing form:			
Does student wear glasses? <input type="checkbox"/> yes <input type="checkbox"/> no			
<i>If answer is 'yes' to any areas below, please provide details in the comment section(s).</i>	Yes	No	Comments
1. As a teacher or parent are you concerned with this student's vision?			
<b>Appearance Symptoms</b>	Yes	No	Comments
2. Tilts head, squints, closes or covers one eye when reading			
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			
<b>Complaints (Student Statements) Symptoms</b>	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 specify)			
9. Complains of blurred or double vision, unusual sensitivity to light, or difficulty seeing (please specify):			
10. History of head injury with vision complaints			
<b>Behavior Symptoms</b>	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 screen			
19. Clumsy; bumps into things; knocks things over			
Other vision concerns:			

**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?  Yes  No  
 Pass  Fail (refer)

Convergence screened?  Yes  No  
 Pass  Fail (refer)

Referred to eye care professional:  Yes  No

Date:

Notes:

School Nurse Name:

School Nurse Signature:

Date: