Vision Symptoms Questionnaire

Utah Department of Health & Human Services 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 or re-evaluated 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:		
School:	Grade:		
Teacher:			
Name/Title of person completing form:			
Does student wear glasses? ☐ yes ☐ no			
Reason for form completion: ☐ Failure to achieve benchmark (grades 1-3) ☐ Special Education referral (any grade) ☐ Special Education re-evaluation (any grade) ☐ Teacher concern (any grade) ☐ parent concern (any grade)			
If answer is 'yes' to any areas below, please provide details in the comment section(s).	Yes	No	Comments
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 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			
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 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			
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. Holds books too close; leans too close to a computer screen			
18. 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:	

***For Schools without a School Nurse or other approved tier 2 vision screener:**		
Schools without a school nurse should have a 'Designated Vision Point-Person' responsible for referring any vision concerns. *This person should not perform a tier 2 vision screening*, but instead should refer any vision concerns to an eye care professional for a complete eye exam. The Designated Vision Point-Person should evaluate any Symptoms Questionnaires and follow the instructions below. This point-person is also responsible for filing the required Vision Screening Annual Report to UDOH by June 30th each year.		
On any question 1-19	If all answers are 'no'	No referral is necessary
On questions 1-10	If one or more answers are 'yes'	Refer to eye care professional
On questions 11-19	If two or more answers are 'yes'	Refer to eye care professional
Distance vision screened: ☐ Pass ☐ Fail (refer)	Referred to eye care professional: ☐ Yes ☐ No	Date:
Notes:		
Designated Vision Point-Person name:		
Signature:	Date:	