

Vision symptoms questionnaire

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

<p>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. The student's parent may also complete this form if they are worried about their student's vision. Give the completed form to the school nurse* for tier 2 evaluation and possible referral to an eye care professional.</p>				
Student name:	Referral date:			
School:	Grade:			
Teacher:				
Name and title of person completing the form:				
Does student wear glasses? <input type="checkbox"/> yes <input type="checkbox"/> no				
Reason for form completion:				
<input type="checkbox"/> Failure to achieve benchmark (grades 1-3, teacher should complete form) <input type="checkbox"/> Special education referral or re-evaluation (any grade, teacher should complete form) <input type="checkbox"/> teacher concern (any grade, teacher should complete form) <input type="checkbox"/> parent concern (any grade, parent should complete form)				
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 (from the student) 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 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 or is referred to an eye care professional, regardless of the answers.

Distance vision screened: <input type="checkbox"/> Pass <input type="checkbox"/> Fail (refer)	Near vision screened: <input type="checkbox"/> Pass <input type="checkbox"/> Fail (refer)
Eye focusing or tracking screened? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pass <input type="checkbox"/> Fail (refer)	Convergence screened? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pass <input type="checkbox"/> Fail (refer)
Referred to eye care professional: <input type="checkbox"/> Yes <input type="checkbox"/> 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* (DVPP) 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 DVPP should evaluate any vision symptoms questionnaires and follow the instructions below. This person is also responsible for filing the required vision screening annual report to Utah Department of Health and Human Services 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: <input type="checkbox"/> Pass <input type="checkbox"/> Fail (refer)	Referred to eye care professional: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date:
Notes:		
Designated vision point-person name:		
Signature:		Date: