Vision Symptom Questionnaire

Utah Department of Health & Human Services in accordance with UCA 53G-9-404 and R384-201

Student name:	Date:
School:	Grade:
Teacher:	
Name and title of person completing the form:	
Does the student wear glasses? ☐ Yes ☐ No	

Teachers must complete this form if a student in grades 1 through 3 does not meet the benchmark on the reading assessment. This form is also needed for a student having a special education evaluation or reevaluation, if the evaluation team says it is needed, or for a student when a parent or teacher has a vision concern. Once completed, please submit the form to the designated vision point person for review. A tier two vision screening or referral to an eye care professional will be done if the vision symptom questionnaire results show it is needed.

Reason for form completion:

☐ Failure to achieve benchmark (grades 1-3, teacher should complete form)

☐ Special education referral or re-evaluation (any grade, teacher should complete form)

☐ Teacher concern (any grade, teacher should complete form)

☐ Parent concern (any grade, parent should complete form)

General symptoms, if yes please comment	**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	☐	☐	
Behavior symptoms	**Yes**	**No**	**Comments**
6. Loses place when reading	☐	☐	
7. Skips over or leaves out small words when reading	☐	☐	
8. Writes uphill or downhill; difficulty writing in a straight line	☐	☐	
9. Has difficulty copying from the board	☐	☐	
10. Avoids near work, such as reading or writing	☐	☐	
11. Has difficulty lining up numbers when doing math	☐	☐	
12. Holds books too close; leans too close to a computer screen	☐	☐	
13. Clumsy; bumps into things; knocks things over	☐	☐	
Complaint (from the student) symptoms	**Yes**	**No**	**Comments**
14. Words float, move, or jump around when reading	☐	☐	
15. Complains of headaches, dizziness, or nausea when reading (please specify)	☐	☐	
16. Complains of itching, burning, or scratchy eyes (please specify)	☐	☐	
17. Complains of blurred or double vision, unusual sensitivity to light, or difficulty seeing (please specify):	☐	☐	
18. History of head injury with vision complaints	☐	☐	
19. Other vision concerns:			

For designated vision point-person use only:

Each school must designate a vision point-person (DVPP) to coordinate vision concerns and vision screening follow-up. If the DVPP is an authorized tier two vision screener, follow the tier two screening section. If the DVPP is not an authorized tier two vision screener, follow the referral instructions below. The DVPP is responsible for documenting referrals and submitting required vision screening data on the School Health Workload Report by June 30 each year.

For authorized tier two screener use only:	
Any parent or teacher concern or any 'yes' answers should be evaluated by the tier two screener to determine if tier two screening or referral to an eye care professional is necessary. **Tier two screeners should use their professional judgment in determining whether the student receives a tier two vision screening or is referred to an eye care professional, regardless of the answers.**	
Required: Tier one distance vision screened ☐ Pass ☐ Refer	Required: Near vision screened ☐ Pass ☐ Refer
Eye focusing or tracking screened? ☐ Yes ☐ No ☐ Pass ☐ Refer	Convergence screened? ☐ Yes ☐ No ☐ Pass ☐ Refer
Referred to an eye care professional: ☐ Yes ☐ No	Date:
Notes:	
Tier two screener name:	
Tier two screener signature:	Date:

Referral instructions when the DVPP is not an authorized tier two vision screener:		
The DVPP is responsible for reviewing completed vision symptoms questionnaires and following the referral instructions below.		
On any question 1-19	If all answers are 'no'	No referral is necessary
Appearance or concern questions 1-5	If one or more answers are 'yes'	Refer to an eye care professional
Behavior questions 6-13	If two or more answers are 'yes'	Refer to an eye care professional
Complaint questions 14-18	If one or more answers are 'yes'	Refer to an eye care professional
Tier one distance vision screened: ☐ Pass ☐ Refer	Referred to an eye care professional: ☐ Yes ☐ No	Date:
Notes:		
DVPP name:		
DVPP Signature:		Date:

USBE Special Education Rules: The special education evaluation team will identify if vision should be ruled out to determine eligibility. The coordination, completion, and review of this questionnaire as part of an initial evaluation or reevaluation are governed exclusively by the Utah State Board of Education Special Education Rules.