

Vision Screening Parent Questionnaire for Children Birth to Age Three

This questionnaire will help gather valuable information about your child's vision. If there are possible vision concerns, we will discuss these with you and whether a visit to a vision professional is needed. This form should be completed by the person who knows your child and family medical history the best. **Please return the completed questionnaire to the email address provided at the end of the document prior to your Early Intervention Evaluation meeting.** If you cannot email the completed questionnaire, please bring it with you to your scheduled meeting.

Child's Name:	Juniper Hilfman	Child's DOB	
Caregiver's Name:		Today's Date:	
Organization:			
Contact Person:		Contact Person's Email:	

Family Vision History (Parents and Siblings)

Is there family history of eye crossing (strabismus) or vision loss due to eye crossing (amblyopia) – grandparent, parents, siblings?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Did anyone in your family need prescription glasses before age 6 years?	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
Please describe any other family vision problems (e.g., retinoblastoma, born with cataracts or glaucoma, etc.).		

Child's Medical History

Has your child been affected by or diagnosed with any of the following? Leave blank if you are unsure or don't know.

Prematurity (i.e., born before 32 weeks).	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
Birth weight less than 4.5 pounds.	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
Needed oxygen more than 4 days as a newborn.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Hearing loss.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Head or facial differences at birth (e.g., cleft lip/palate, craniosynostosis, etc.).	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Prenatal exposure to infections (e.g., CMV, syphilis, rubella, toxoplasmosis, etc.).	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Meningitis or encephalitis.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Prenatal exposure to drugs or alcohol.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Any type of syndrome (e.g., Down Syndrome, CHARGE Syndrome, etc.).	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Brain injury (e.g., lack of oxygen, stroke, accidental or non-accidental trauma, etc.).	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Neurological conditions (e.g., cerebral palsy, infantile spasms or other seizure disorders, hydrocephalus, etc.).	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Delayed Visual Maturation or Cortical/Cerebral Visual Impairment (CVI).	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>

Eye Doctor Examination

Has an eye doctor examined your child's eyes?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
If yes, when was the most recent exam (month, year)?		
What were the results of the exam?		
Were eyeglasses or another treatment prescribed?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If the doctor prescribed eyeglasses, does your child wear them?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If your child does not wear their glasses, what is the reason?		

We can learn a lot about the health of your child's vision by looking at the appearance of their eyes and eyelids, observing their visual behaviors, and listening to your concerns about your child's vision.

Appearance of Eyes and Eyelids

Please take a few moments to look at your child's eyes and eyelids. Answer yes or no to the following questions. If you are unsure, leave the question blank.

Does one eye look different than the other eye? For example, one eye looks much smaller, or one eye is higher on the face than the other eye.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Do one or both eyes turn in, out, up, or down? This may happen all of the time or only some of the time.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Is there a difference in the black color, size, or shape of the pupils in one or both eyes? The pupil is the dark black center of each eye.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Is there a difference in the size and shape of the iris in one or both eyes? The iris is the colored part of each eye.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Do one or both of their eyes appear white or cloudy?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Do their eyes involuntarily move or rapidly move – dancing/ jiggling up and down or side to side?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Are their eye(s) red and/or excessively mattered beyond the usual sleep matter when the child first awakens or due to allergies?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Are their eyelids red, swollen, and/or encrusted?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Does one eyelid droop or appear lower than the other?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>

If you answered "yes" to any of the questions above, when did you first notice it? Did this happen suddenly? Please describe.

Behaviors

Your child's actions may indicate that something may not be right with their vision. Please think about how your child uses their vision during the day. Answer yes or no to the statements below. If you are unsure, leave the statement blank.

My child...

Answer the following statement for children one month or older

1. Has difficulty looking at and making eye contact with me for at least 3 seconds.	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
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And answer the following statements for children three months or older

2. Tilts or turns their head to the side, lifts or lowers their chin, and/or thrusts their head forward or backward when looking at something at near or far range. Circle which behavior you notice.	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
3. Holds an object very close to their eyes (within 1-4 inches) when looking at it.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
4. Has trouble seeing small objects such as a piece of lint, or a small piece of cereal left on a tray or table.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
5. Frowns, squints, or covers an eye when looking at something at near or far distance.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>

6. Appears to be looking over, under, or beside people or objects rather than looking straight at them.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
7. Shows more interest in looking at overhead lights or windows than looking at people or toys.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
8. Struggles to recognize familiar people before hearing their voices.	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
9. Recognizes a familiar toy only after touching or hearing it.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
10. Only sees an object when it is separated from other items. For example, cannot find a specific toy when it is among other objects.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
11. Notices people, pets, or objects only when they are moving.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
12. Looks away when reaching toward a nearby object.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
13. Reaches over or under something when they are trying to grasp it.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>

And answer the following statements for children who are 12 months or older

14. Has difficulty detecting a change in a floor surface, such as from tile to carpet.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
15. Frequently stumbles over objects or bumps into things that are in their path. Hesitates or misses detecting a step or a curb.	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
16. Avoids looking at or pointing to pictures in books or on a screen.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
17. Has a hard time finding small details in pictures (e.g., when asked to point to a dog's nose).	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
18. Has difficulty seeing or pointing to something over 20 feet away, such as a dog across the street, an airplane flying overhead.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>

Caregiver Concerns

Do you have any concerns about your child's vision that were not addressed in the earlier questions?
If yes, please describe.

No concerns

Next Steps:

Please return this questionnaire to the email address below prior to your evaluation or meeting. If you cannot email the completed questionnaire, please bring it with you to your meeting.

To Be Completed by Vision Screening Professional – when was Parent Questionnaire completed?

EI Evaluation

IFSP (initial, annual, periodic review)

Other

References:

Colorado Department of Education (2005). *Visual Screening Guidelines: Children Birth through Five Years*.

Teach CVI (2020). *Screening List for Children with a Suspicion of a Cerebral Visual Impairment (CVI) / Screen List CVI 1*. Click [HERE](#) for the document.

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Caregiver's Name:		Today's Date:	
Organization:			
Contact Person:		Contact Person's Email:	

Family Vision History (Parents and Siblings)

Is there family history of eye crossing (strabismus) or vision loss due to eye crossing (amblyopia) – grandparent, parents, siblings?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Did anyone in your family need prescription glasses before age 6 years?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Please describe any other family vision problems (e.g., retinoblastoma, born with cataracts or glaucoma, etc.).		

Child's Medical History

Has your child been affected by or diagnosed with any of the following? Leave blank if you are unsure or don't know.

Prematurity (i.e., born before 32 weeks).	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Birth weight less than 4.5 pounds.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Needed oxygen more than 4 days as a newborn.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Hearing loss.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Head or facial differences at birth (e.g., cleft lip/palate, craniosynostosis, etc.).	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Prenatal exposure to infections (e.g., CMV, syphilis, rubella, toxoplasmosis, etc.).	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Meningitis or encephalitis.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Prenatal exposure to drugs or alcohol.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Any type of syndrome (e.g., Down Syndrome, CHARGE Syndrome, etc.).	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Brain injury (e.g., lack of oxygen, stroke, accidental or non-accidental trauma, etc.).	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Neurological conditions (e.g., cerebral palsy, infantile spasms or other seizure disorders, hydrocephalus, etc.).	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Delayed Visual Maturation or Cortical/Cerebral Visual Impairment (CVI).	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>

Eye Doctor Examination

Has an eye doctor examined your child's eyes?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
If yes, when was the most recent exam (month, year)?		
What were the results of the exam?		
Were eyeglasses or another treatment prescribed?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If the doctor prescribed eyeglasses, does your child wear them?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If your child does not wear their glasses, what is the reason?		

We can learn a lot about the health of your child's vision by looking at the appearance of their eyes and eyelids, observing their visual behaviors, and listening to your concerns about your child's vision.

Appearance of Eyes and Eyelids

Please take a few moments to look at your child's eyes and eyelids. Answer yes or no to the following questions. If you are unsure, leave the question blank.

Does one eye look different than the other eye? For example, one eye looks much smaller, or one eye is higher on the face than the other eye.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Do one or both eyes turn in, out, up, or down? This may happen all of the time or only some of the time.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Is there a difference in the black color, size, or shape of the pupils in one or both eyes? The pupil is the dark black center of each eye.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Is there a difference in the size and shape of the iris in one or both eyes? The iris is the colored part of each eye.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Do one or both of their eyes appear white or cloudy?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Do their eyes involuntarily move or rapidly move – dancing/ jiggling up and down or side to side?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Are their eye(s) red and/or excessively mattered beyond the usual sleep matter when the child first awakens or due to allergies?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Are their eyelids red, swollen, and/or encrusted?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Does one eyelid droop or appear lower than the other?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>

If you answered "yes" to any of the questions above, when did you first notice it? Did this happen suddenly? Please describe.

Behaviors

Your child's actions may indicate that something may not be right with their vision. Please think about how your child uses their vision during the day. Answer yes or no to the statements below. If you are unsure, leave the statement blank.

My child...

Answer the following statement for children one month or older

1. Has difficulty looking at and making eye contact with me for at least 3 seconds.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
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And answer the following statements for children three months or older

2. Tilts or turns their head to the side, lifts or lowers their chin, and/or thrusts their head forward or backward when looking at something at near or far range. Circle which behavior you notice.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
3. Holds an object very close to their eyes (within 1-4 inches) when looking at it.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
4. Has trouble seeing small objects such as a piece of lint, or a small piece of cereal left on a tray or table.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
5. Frowns, squints, or covers an eye when looking at something at near or far distance.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>

6. Appears to be looking over, under, or beside people or objects rather than looking straight at them.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
7. Shows more interest in looking at overhead lights or windows than looking at people or toys.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
8. Struggles to recognize familiar people before hearing their voices.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
9. Recognizes a familiar toy only after touching or hearing it.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
10. Only sees an object when it is separated from other items. For example, cannot find a specific toy when it is among other objects.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
11. Notices people, pets, or objects only when they are moving.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
12. Looks away when reaching toward a nearby object.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
13. Reaches over or under something when they are trying to grasp it.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>

And answer the following statements for children who are 12 months or older

14. Has difficulty detecting a change in a floor surface, such as from tile to carpet.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
15. Frequently stumbles over objects or bumps into things that are in their path. Hesitates or misses detecting a step or a curb.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
16. Avoids looking at or pointing to pictures in books or on a screen.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
17. Has a hard time finding small details in pictures (e.g., when asked to point to a dog's nose).	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
18. Has difficulty seeing or pointing to something over 20 feet away, such as a dog across the street, an airplane flying overhead.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>

Caregiver Concerns

Do you have any concerns about your child's vision that were not addressed in the earlier questions?
If yes, please describe.

No concerns

Next Steps:

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To Be Completed by Vision Screening Professional – when was Parent Questionnaire completed?

- EI Evaluation IFSP (initial, annual, periodic review) Other

References:

Colorado Department of Education (2005). *Visual Screening Guidelines: Children Birth through Five Years*.

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Child's Name:	Ezequiel Montes	Child's DOB	
Caregiver's Name:		Today's Date:	
Organization:			
Contact Person:		Contact Person's Email:	

Family Vision History (Parents and Siblings)

Is there family history of eye crossing (strabismus) or vision loss due to eye crossing (amblyopia) – grandparent, parents, siblings?	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
Did anyone in your family need prescription glasses before age 6 years?	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
Please describe any other family vision problems (e.g., retinoblastoma, born with cataracts or glaucoma, etc.).		

Child's Medical History

Has your child been affected by or diagnosed with any of the following? Leave blank if you are unsure or don't know.

Prematurity (i.e., born before 32 weeks).	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Birth weight less than 4.5 pounds.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Needed oxygen more than 4 days as a newborn.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Hearing loss.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Head or facial differences at birth (e.g., cleft lip/palate, craniosynostosis, etc.).	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Prenatal exposure to infections (e.g., CMV, syphilis, rubella, toxoplasmosis, etc.).	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Meningitis or encephalitis.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Prenatal exposure to drugs or alcohol.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Any type of syndrome (e.g., Down Syndrome, CHARGE Syndrome, etc.).	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Brain injury (e.g., lack of oxygen, stroke, accidental or non-accidental trauma, etc.).	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Neurological conditions (e.g., cerebral palsy, infantile spasms or other seizure disorders, hydrocephalus, etc.).	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Delayed Visual Maturation or Cortical/Cerebral Visual Impairment (CVI).	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>

Eye Doctor Examination

Has an eye doctor examined your child's eyes?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
If yes, when was the most recent exam (month, year)?		
What were the results of the exam?		
Were eyeglasses or another treatment prescribed?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If the doctor prescribed eyeglasses, does your child wear them?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If your child does not wear their glasses, what is the reason?		

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My child...

Answer the following statement for children **one month or older**

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4. Has trouble seeing small objects such as a piece of lint, or a small piece of cereal left on a tray or table.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
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Caregiver Concerns

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No concerns

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Child’s Name:	Mya Reid	Child’s DOB	
Caregiver’s Name:		Today’s Date:	
Organization:			
Contact Person:		Contact Person’s Email:	

Family Vision History (Parents and Siblings)

Is there family history of eye crossing (strabismus) or vision loss due to eye crossing (amblyopia) – grandparent, parents, siblings?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
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Prenatal exposure to infections (e.g., CMV, syphilis, rubella, toxoplasmosis, etc.).	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Meningitis or encephalitis.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Prenatal exposure to drugs or alcohol.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Any type of syndrome (e.g., Down Syndrome, CHARGE Syndrome, etc.).	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Brain injury (e.g., lack of oxygen, stroke, accidental or non-accidental trauma, etc.).	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Neurological conditions (e.g., cerebral palsy, infantile spasms or other seizure disorders, hydrocephalus, etc.).	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Delayed Visual Maturation or Cortical/Cerebral Visual Impairment (CVI).	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>

Eye Doctor Examination

Has an eye doctor examined your child's eyes?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
If yes, when was the most recent exam (month, year)?		
What were the results of the exam?		
Were eyeglasses or another treatment prescribed?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If the doctor prescribed eyeglasses, does your child wear them?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If your child does not wear their glasses, what is the reason?		

We can learn a lot about the health of your child's vision by looking at the appearance of their eyes and eyelids, observing their visual behaviors, and listening to your concerns about your child's vision.

Appearance of Eyes and Eyelids

Please take a few moments to look at your child's eyes and eyelids. Answer yes or no to the following questions. If you are unsure, leave the question blank.

Does one eye look different than the other eye? For example, one eye looks much smaller, or one eye is higher on the face than the other eye.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Do one or both eyes turn in, out, up, or down? This may happen all of the time or only some of the time.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Is there a difference in the black color, size, or shape of the pupils in one or both eyes? The pupil is the dark black center of each eye.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Is there a difference in the size and shape of the iris in one or both eyes? The iris is the colored part of each eye.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Do one or both of their eyes appear white or cloudy?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Do their eyes involuntarily move or rapidly move – dancing/ jiggling up and down or side to side?	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
Are their eye(s) red and/or excessively mattered beyond the usual sleep matter when the child first awakens or due to allergies?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Are their eyelids red, swollen, and/or encrusted?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Does one eyelid droop or appear lower than the other?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>

<p>If you answered "yes" to any of the questions above, when did you first notice it? Did this happen suddenly? Please describe.</p> <p>I noticed the eye movement about two weeks ago.</p>

Behaviors

Your child's actions may indicate that something may not be right with their vision. Please think about how your child uses their vision during the day. Answer yes or no to the statements below. If you are unsure, leave the statement blank.

My child...

Answer the following statement for children one month or older

1. Has difficulty looking at and making eye contact with me for at least 3 seconds.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
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And answer the following statements for children three months or older

2. Tilts or turns their head to the side, lifts or lowers their chin, and/or thrusts their head forward or backward when looking at something at near or far range. Circle which behavior you notice.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
3. Holds an object very close to their eyes (within 1-4 inches) when looking at it.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
4. Has trouble seeing small objects such as a piece of lint, or a small piece of cereal left on a tray or table.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
5. Frowns, squints, or covers an eye when looking at something at near or far distance.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>

6. Appears to be looking over, under, or beside people or objects rather than looking straight at them.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
7. Shows more interest in looking at overhead lights or windows than looking at people or toys.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
8. Struggles to recognize familiar people before hearing their voices.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
9. Recognizes a familiar toy only after touching or hearing it.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
10. Only sees an object when it is separated from other items. For example, cannot find a specific toy when it is among other objects.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
11. Notices people, pets, or objects only when they are moving.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
12. Looks away when reaching toward a nearby object.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
13. Reaches over or under something when they are trying to grasp it.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>

And answer the following statements for children who are 12 months or older

14. Has difficulty detecting a change in a floor surface, such as from tile to carpet.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
15. Frequently stumbles over objects or bumps into things that are in their path. Hesitates or misses detecting a step or a curb.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
16. Avoids looking at or pointing to pictures in books or on a screen.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
17. Has a hard time finding small details in pictures (e.g., when asked to point to a dog's nose).	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
18. Has difficulty seeing or pointing to something over 20 feet away, such as a dog across the street, an airplane flying overhead.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>

Caregiver Concerns

Do you have any concerns about your child's vision that were not addressed in the earlier questions?
If yes, please describe.

No concerns

Next Steps:

Please return this questionnaire to the email address below prior to your evaluation or meeting. If you cannot email the completed questionnaire, please bring it with you to your meeting.

To Be Completed by Vision Screening Professional – when was Parent Questionnaire completed?

EI Evaluation

IFSP (initial, annual, periodic review)

Other

References:

Colorado Department of Education (2005). *Visual Screening Guidelines: Children Birth through Five Years*.

Teach CVI (2020). *Screening List for Children with a Suspicion of a Cerebral Visual Impairment (CVI) / Screen List CVI 1*. Click [HERE](#) for the document.

Topor, I. (2004). *Approximate functional visual acuity for different sizes of objects and distances*. Chapel Hill, NC: Early Intervention Training Center for Infants and Toddlers with Visual Impairments, FPG Child Development Institute, UNC-CH.

Vision Screening Parent Questionnaire for Children Birth to Age Three

This questionnaire will help gather valuable information about your child's vision. If there are possible vision concerns, we will discuss these with you and whether a visit to a vision professional is needed. This form should be completed by the person who knows your child and family medical history the best. **Please return the completed questionnaire to the email address provided at the end of the document prior to your Early Intervention Evaluation meeting.** If you cannot email the completed questionnaire, please bring it with you to your scheduled meeting.

Child's Name:	Kaylani Shaver	Child's DOB	
Caregiver's Name:		Today's Date:	
Organization:			
Contact Person:		Contact Person's Email:	

Family Vision History (Parents and Siblings)

Is there family history of eye crossing (strabismus) or vision loss due to eye crossing (amblyopia) – grandparent, parents, siblings?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Did anyone in your family need prescription glasses before age 6 years?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Please describe any other family vision problems (e.g., retinoblastoma, born with cataracts or glaucoma, etc.).		

Child's Medical History

Has your child been affected by or diagnosed with any of the following? Leave blank if you are unsure or don't know.

Prematurity (i.e., born before 32 weeks).	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Birth weight less than 4.5 pounds.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Needed oxygen more than 4 days as a newborn.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Hearing loss.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Head or facial differences at birth (e.g., cleft lip/palate, craniosynostosis, etc.).	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Prenatal exposure to infections (e.g., CMV, syphilis, rubella, toxoplasmosis, etc.).	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Meningitis or encephalitis.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Prenatal exposure to drugs or alcohol.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Any type of syndrome (e.g., Down Syndrome, CHARGE Syndrome, etc.).	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Brain injury (e.g., lack of oxygen, stroke, accidental or non-accidental trauma, etc.).	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Neurological conditions (e.g., cerebral palsy, infantile spasms or other seizure disorders, hydrocephalus, etc.).	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Delayed Visual Maturation or Cortical/Cerebral Visual Impairment (CVI).	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>

Eye Doctor Examination

Has an eye doctor examined your child's eyes?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
If yes, when was the most recent exam (month, year)?		
What were the results of the exam?		
Were eyeglasses or another treatment prescribed?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If the doctor prescribed eyeglasses, does your child wear them?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If your child does not wear their glasses, what is the reason?		

We can learn a lot about the health of your child's vision by looking at the appearance of their eyes and eyelids, observing their visual behaviors, and listening to your concerns about your child's vision.

Appearance of Eyes and Eyelids

Please take a few moments to look at your child's eyes and eyelids. Answer yes or no to the following questions. If you are unsure, leave the question blank.

Does one eye look different than the other eye? For example, one eye looks much smaller, or one eye is higher on the face than the other eye.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Do one or both eyes turn in, out, up, or down? This may happen all of the time or only some of the time.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Is there a difference in the black color, size, or shape of the pupils in one or both eyes? The pupil is the dark black center of each eye.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Is there a difference in the size and shape of the iris in one or both eyes? The iris is the colored part of each eye.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Do one or both of their eyes appear white or cloudy?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Do their eyes involuntarily move or rapidly move – dancing/ jiggling up and down or side to side?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Are their eye(s) red and/or excessively mattered beyond the usual sleep matter when the child first awakens or due to allergies?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Are their eyelids red, swollen, and/or encrusted?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Does one eyelid droop or appear lower than the other?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>

If you answered "yes" to any of the questions above, when did you first notice it? Did this happen suddenly? Please describe.

Behaviors

Your child's actions may indicate that something may not be right with their vision. Please think about how your child uses their vision during the day. Answer yes or no to the statements below. If you are unsure, leave the statement blank.

My child...

Answer the following statement for children one month or older

1. Has difficulty looking at and making eye contact with me for at least 3 seconds.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
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And answer the following statements for children three months or older

2. Tilts or turns their head to the side, lifts or lowers their chin, and/or thrusts their head forward or backward when looking at something at near or far range. Circle which behavior you notice.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
3. Holds an object very close to their eyes (within 1-4 inches) when looking at it.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
4. Has trouble seeing small objects such as a piece of lint, or a small piece of cereal left on a tray or table.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
5. Frowns, squints, or covers an eye when looking at something at near or far distance.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>

6. Appears to be looking over, under, or beside people or objects rather than looking straight at them.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
7. Shows more interest in looking at overhead lights or windows than looking at people or toys.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
8. Struggles to recognize familiar people before hearing their voices.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
9. Recognizes a familiar toy only after touching or hearing it.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
10. Only sees an object when it is separated from other items. For example, cannot find a specific toy when it is among other objects.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
11. Notices people, pets, or objects only when they are moving.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
12. Looks away when reaching toward a nearby object.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
13. Reaches over or under something when they are trying to grasp it.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>

And answer the following statements for children who are 12 months or older

14. Has difficulty detecting a change in a floor surface, such as from tile to carpet.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
15. Frequently stumbles over objects or bumps into things that are in their path. Hesitates or misses detecting a step or a curb.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
16. Avoids looking at or pointing to pictures in books or on a screen.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
17. Has a hard time finding small details in pictures (e.g., when asked to point to a dog's nose).	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
18. Has difficulty seeing or pointing to something over 20 feet away, such as a dog across the street, an airplane flying overhead.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>

Caregiver Concerns

Do you have any concerns about your child's vision that were not addressed in the earlier questions?
If yes, please describe.

Kaylani does not make eye contact with people who hold her. Is this a problem?

Next Steps:

Please return this questionnaire to the email address below prior to your evaluation or meeting. If you cannot email the completed questionnaire, please bring it with you to your meeting.

To Be Completed by Vision Screening Professional – when was Parent Questionnaire completed?

- EI Evaluation IFSP (initial, annual, periodic review) Other

References:

Colorado Department of Education (2005). *Visual Screening Guidelines: Children Birth through Five Years*.

Teach CVI (2020). *Screening List for Children with a Suspicion of a Cerebral Visual Impairment (CVI) / Screen List CVI 1*. Click [HERE](#) for the document.

Topor, I. (2004). *Approximate functional visual acuity for different sizes of objects and distances*. Chapel Hill, NC: Early Intervention Training Center for Infants and Toddlers with Visual Impairments, FPG Child Development Institute, UNC-CH.

Vision Screening Parent Questionnaire for Children Birth to Age Three

This questionnaire will help gather valuable information about your child's vision. If there are possible vision concerns, we will discuss these with you and whether a visit to a vision professional is needed. This form should be completed by the person who knows your child and family medical history the best. **Please return the completed questionnaire to the email address provided at the end of the document prior to your Early Intervention Evaluation meeting.** If you cannot email the completed questionnaire, please bring it with you to your scheduled meeting.

Child's Name:	Zoe Willis	Child's DOB	
Caregiver's Name:		Today's Date:	
Organization:			
Contact Person:		Contact Person's Email:	

Family Vision History (Parents and Siblings)

Is there family history of eye crossing (strabismus) or vision loss due to eye crossing (amblyopia) – grandparent, parents, siblings?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Did anyone in your family need prescription glasses before age 6 years?	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
Please describe any other family vision problems (e.g., retinoblastoma, born with cataracts or glaucoma, etc.).		

Child's Medical History

Has your child been affected by or diagnosed with any of the following? Leave blank if you are unsure or don't know.

Prematurity (i.e., born before 32 weeks).	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Birth weight less than 4.5 pounds.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Needed oxygen more than 4 days as a newborn.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Hearing loss.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Head or facial differences at birth (e.g., cleft lip/palate, craniosynostosis, etc.).	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Prenatal exposure to infections (e.g., CMV, syphilis, rubella, toxoplasmosis, etc.).	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Meningitis or encephalitis.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Prenatal exposure to drugs or alcohol.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Any type of syndrome (e.g., Down Syndrome, CHARGE Syndrome, etc.).	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Brain injury (e.g., lack of oxygen, stroke, accidental or non-accidental trauma, etc.).	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Neurological conditions (e.g., cerebral palsy, infantile spasms or other seizure disorders, hydrocephalus, etc.).	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Delayed Visual Maturation or Cortical/Cerebral Visual Impairment (CVI).	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>

Eye Doctor Examination

Has an eye doctor examined your child's eyes?	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
If yes, when was the most recent exam (month, year)?		
What were the results of the exam? Near sighted		
Were eyeglasses or another treatment prescribed?	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
If the doctor prescribed eyeglasses, does your child wear them?	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
If your child does not wear their glasses, what is the reason?		

We can learn a lot about the health of your child's vision by looking at the appearance of their eyes and eyelids, observing their visual behaviors, and listening to your concerns about your child's vision.

Appearance of Eyes and Eyelids

Please take a few moments to look at your child's eyes and eyelids. Answer yes or no to the following questions. If you are unsure, leave the question blank.

Does one eye look different than the other eye? For example, one eye looks much smaller, or one eye is higher on the face than the other eye.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Do one or both eyes turn in, out, up, or down? This may happen all of the time or only some of the time.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Is there a difference in the black color, size, or shape of the pupils in one or both eyes? The pupil is the dark black center of each eye.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Is there a difference in the size and shape of the iris in one or both eyes? The iris is the colored part of each eye.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Do one or both of their eyes appear white or cloudy?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Do their eyes involuntarily move or rapidly move – dancing/ jiggling up and down or side to side?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Are their eye(s) red and/or excessively mattered beyond the usual sleep matter when the child first awakens or due to allergies?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Are their eyelids red, swollen, and/or encrusted?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Does one eyelid droop or appear lower than the other?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>

If you answered "yes" to any of the questions above, when did you first notice it? Did this happen suddenly? Please describe.

Behaviors

Your child's actions may indicate that something may not be right with their vision. Please think about how your child uses their vision during the day. Answer yes or no to the statements below. If you are unsure, leave the statement blank.

My child...

Answer the following statement for children **one month or older**

1. Has difficulty looking at and making eye contact with me for at least 3 seconds.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
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And answer the following statements for children **three months or older**

2. Tilts or turns their head to the side, lifts or lowers their chin, and/or thrusts their head forward or backward when looking at something at near or far range. Circle which behavior you notice.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
3. Holds an object very close to their eyes (within 1-4 inches) when looking at it.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
4. Has trouble seeing small objects such as a piece of lint, or a small piece of cereal left on a tray or table.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
5. Frowns, squints, or covers an eye when looking at something at near or far distance.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>

6. Appears to be looking over, under, or beside people or objects rather than looking straight at them.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
7. Shows more interest in looking at overhead lights or windows than looking at people or toys.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
8. Struggles to recognize familiar people before hearing their voices.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
9. Recognizes a familiar toy only after touching or hearing it.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
10. Only sees an object when it is separated from other items. For example, cannot find a specific toy when it is among other objects.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
11. Notices people, pets, or objects only when they are moving.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
12. Looks away when reaching toward a nearby object.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
13. Reaches over or under something when they are trying to grasp it.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>

And answer the following statements for children who are **12 months or older**

14. Has difficulty detecting a change in a floor surface, such as from tile to carpet.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
15. Frequently stumbles over objects or bumps into things that are in their path. Hesitates or misses detecting a step or a curb.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
16. Avoids looking at or pointing to pictures in books or on a screen.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
17. Has a hard time finding small details in pictures (e.g., when asked to point to a dog's nose).	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
18. Has difficulty seeing or pointing to something over 20 feet away, such as a dog across the street, an airplane flying overhead.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>

Caregiver Concerns

Do you have any concerns about your child's vision that were not addressed in the earlier questions?
If yes, please describe.

none

Next Steps:

Please return this questionnaire to the email address below prior to your evaluation or meeting. If you cannot email the completed questionnaire, please bring it with you to your meeting.

To Be Completed by Vision Screening Professional – when was Parent Questionnaire completed?

- EI Evaluation IFSP (initial, annual, periodic review) Other

References:

Colorado Department of Education (2005). *Visual Screening Guidelines: Children Birth through Five Years*.

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