COLORADO
Department of Education

Vision Screening Parent Questionnaire for Children Ages Birth through Five Years

This tool has been developed to address cursory vision screening practices for children ages birth through five years of age. It should be completed by a caregiver who knows the child best. The information will determine if there are vision concerns that warrant further evaluation when in-person screening or assessment activities can resume.

Child's Name: Rehan Castro **Child's DOB:** 12/7/18

Caregiver Name: _____ **Date:** _____

Community Center Board: _____ **District:** _____

Contact Person: _____ **Email:** _____

It is important to have information about possible vision concerns that may occur with other family members, as well as general medical information about your child.

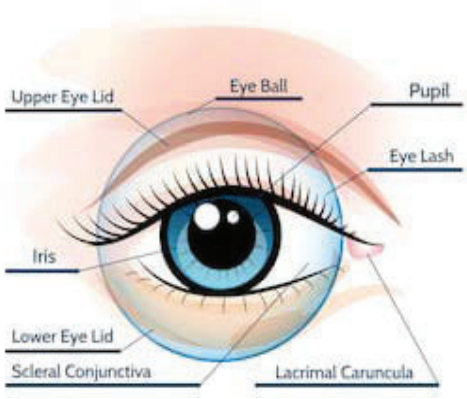
General History: High Risk Populations for Visual Problems

Is there a family history of early onset vision loss (e.g., cataracts, albinism, etc.?)	**Yes** ☐	**No** ■
Is there a family history of eye crossing, color vision problems, and/or needing prescription glasses?	**Yes** ☐	**No** ■
Was your child exposed to any prenatal infections (e.g. toxoplasmosis, CMV)?	**Yes** ☐	**No** ■
Did your baby weigh fewer than three pounds at birth?	**Yes** ☐	**No** ■
Was your child born prematurely?	**Yes** ☐	**No** ■
Was your child exposed to alcohol or drugs before birth?	**Yes** ☐	**No** ■
Has your child had meningitis or encephalitis?	**Yes** ☐	**No** ■
Has your child experienced any form of brain injury / head trauma? (in utero stroke, brain hemorrhage, lack of oxygen, accidental or non-accidental trauma)	**Yes** ☐	**No** ■
Does your child have any neurological disorders (e.g. seizures, hydrocephaly)?	**Yes** ☐	**No** ■
Does your child have any difficulties with his or her hearing?	**Yes** ☐	**No** ■
Has your child been diagnosed with a syndrome (e.g. Down syndrome, CHARGE syndrome, etc.?)	**Yes** ☐	**No** ■
Has your child been diagnosed as having cerebral palsy?	**Yes** ☐	**No** ■

The ABCs of Early Vision Problems

Background Information: We can learn a lot about the health and well-being of a young child's vision by paying attention to the appearance of his or her eyes, visual behaviors, and complaints. Thank you for your assistance with this information to determine if there is a concern about your child's vision.

Appearance of the Eyes / Eyelids: Please take a few moments to observe the child eyes and eyelids. Answer yes or no the statements below. If you are unsure, leave the question blank for consultation from Part C or school district Child Find professionals with appropriate expertise.



One eye looks different than the other eye. For example, one eye is significantly smaller in appearance or one eye is higher on the face than the other eye.	**Yes** ☐	**No** ☑
One or both eyes turn inward or outward. This can happen all of the time or only some of the time.	**Yes** ☐	**No** ■
There is 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** ☐	**No** ■
There is 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** ☐	**No** ■
One or both eyes appear white or cloudy.	**Yes** ☐	**No** ■
Eyes are in involuntary, rapid (dancing/ jiggling up and down or side to side) motion.	**Yes** ☐	**No** ■
Eye(s) are red and/or excessively mattered (beyond the usual sleep matter when the child first awakens or due to allergies).	**Yes** ☐	**No** ■
Eyelids are red, swollen, and/or are encrusted.	**Yes** ☐	**No** ■
An eyelid(s) is drooping or appears lower than the other.	**Yes** ☐	**No** ■

Behavior: Please report your observations of how your child uses vision in daily tasks. Answer yes or no the statements below. If you are unsure, leave the question blank for consultation from Part C or school district Child Find professionals with appropriate expertise.

Does your child ….

Consistently NOT make eye contact with familiar people (after two months of age).	**Yes** ☐	**No** ▣
Cover or close an eye when looking at someone or something within close range (two feet or closer).	**Yes** ☐	**No** ▣
Frown or squint an eye when looking at something far away (two feet or further).	**Yes** ☐	**No** ▣
Tilt / turn head to the side, lift /lower chin, and/or thrust head forward or backward when looking at something at near or far range. *Circle which behavior occurs.*	**Yes** ☐	**No** ▣
Close eyes or turns face away when listening to others talk.	**Yes** ☐	**No** ▣
Does not smile in response to another person's smile.	**Yes** ☐	**No** ▣
Hold an object very close to his or her eyes when looking at it.	**Yes** ☐	**No** ▣
Stare at lights sources (overhead lights or windows) for a long period of time.	**Yes** ☐	**No** ▣
Prefer certain colors; chooses items with these colors over items with other colors. (e.g., seems to look more intently at objects that are red.)	**Yes** ☐	**No** ▣
Recognize familiar people only after they speak.	**Yes** ☐	**No** ▣
Notice people, pets, or objects only when they are moving	**Yes** ☐	**No** ▣
Seem to have inconsistent visual abilities (e.g. seems to change from morning to night or from day to day or between activities).	**Yes** ☐	**No** ▣
Miss objects he or she is simultaneously looking at and reaching for (e.g. require multiple attempts to get the item).	**Yes** ☐	**No** ▣
Look away when reaching toward a nearby object.	**Yes** ☐	**No** ▣
Stumble frequently over objects that are in his or her path or bump into walls.	**Yes** ☐	**No** ▣
Have difficulties detecting a change in floor surface, such as from tile to carpet. Hesitate or miss detecting step or a curb.	**Yes** ☐	**No** ▣
Have trouble seeing small objects, such as a small piece of cereal left on tray / table.	**Yes** ☐	**No** ▣
Lose interest quickly in games, projects or activities that require using his or her eyes for an extended period of time.	**Yes** ☐	**No** ▣
Avoid looking at books, drawing, playing games or doing other projects that require focusing up close.	**Yes** ☐	**No** ▣

Complaints: A young child will not usually "complain" about visual difficulties, but may show through behavior that something is not right with his or her vision. Answer yes or no the statements below. If you are unsure, leave the question blank for consultation from Part C or school district Child Find professionals with appropriate expertise.

Does your child ….

Appear to be overly sensitive to bright indoor lights or the sunlight. Squint excessively, put a hand over his eyes, or put his head down to avoid the light.	**Yes** ☐	**No** ■
Seem to have burning or itchy eyes, rub his or her eyes, rapidly blink, and/or have teary eyes not due to allergies.	**Yes** ☐	**No** ■
Rub his or her eyes or blink rapidly after looking at something (when he or she is not tired).	**Yes** ☐	**No** ■
Appear to only see an object when it's separated (isolated?) from other items (e.g. cannot find a specific toy when it's among other objects).	**Yes** ☐	**No** ■

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

None

Has your child ever been seen by an eye doctor (optometrist or ophthalmologist?) Yes ☐ No ■

If yes, what were the results of the exam? _____

Were glasses or another treatment prescribed? Yes ☐ No ☐

If yes, does your child wear the glasses, as prescribed? Yes ☐ No ☐

If not, what is the reason the child is not wearing his or her glasses:

Next Steps: Thank you for providing information about your child's vision. This information will be reviewed with your Part C or Child Find contact person to determine appropriate next steps.

References:

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

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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.

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Child's Name: Juniper Hilfman **Child's DOB:** 6/29/19

Caregiver Name: _____ **Date:** _____

Community Center Board: _____ **District:** _____

Contact Person: _____ **Email:** _____

It is important to have information about possible vision concerns that may occur with other family members, as well as general medical information about your child.

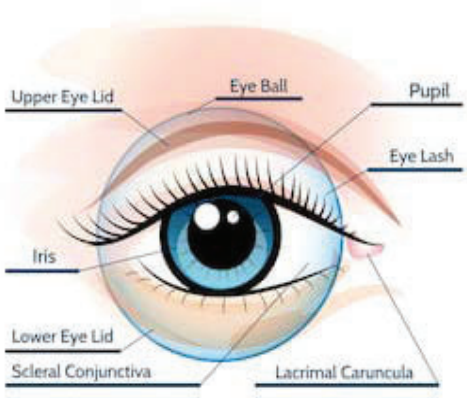
General History: High Risk Populations for Visual Problems

Is there a family history of early onset vision loss (e.g., cataracts, albinism, etc.?)	Yes ☐	No ■
Is there a family history of eye crossing, color vision problems, and/or needing prescription glasses?	Yes ■	No ☐
Was your child exposed to any prenatal infections (e.g. toxoplasmosis, CMV)?	Yes ☐	No ■
Did your baby weigh fewer than three pounds at birth?	Yes ■	No ☐
Was your child born prematurely?	Yes ■	No ☐
Was your child exposed to alcohol or drugs before birth?	Yes ☐	No ■
Has your child had meningitis or encephalitis?	Yes ☐	No ■
Has your child experienced any form of brain injury / head trauma? (in utero stroke, brain hemorrhage, lack of oxygen, accidental or non-accidental trauma)	Yes ☐	No ■
Does your child have any neurological disorders (e.g. seizures, hydrocephaly)?	Yes ☐	No ■
Does your child have any difficulties with his or her hearing?	Yes ■	No ☐
Has your child been diagnosed with a syndrome (e.g. Down syndrome, CHARGE syndrome, etc.?)	Yes ☐	No ■
Has your child been diagnosed as having cerebral palsy?	Yes ☐	No ■

The ABCs of Early Vision Problems

Background Information: We can learn a lot about the health and well-being of a young child's vision by paying attention to the appearance of his or her eyes, visual behaviors, and complaints. Thank you for your assistance with this information to determine if there is a concern about your child's vision.

Appearance of the Eyes / Eyelids: Please take a few moments to observe the child eyes and eyelids. Answer yes or no the statements below. If you are unsure, leave the question blank for consultation from Part C or school district Child Find professionals with appropriate expertise.



One eye looks different than the other eye. For example, one eye is significantly smaller in appearance or one eye is higher on the face than the other eye.	**Yes** ☐	**No** ☑
One or both eyes turn inward or outward. This can happen all of the time or only some of the time.	**Yes** ☐	**No** ■
There is 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** ☐	**No** ■
There is 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** ☐	**No** ■
One or both eyes appear white or cloudy.	**Yes** ☐	**No** ■
Eyes are in involuntary, rapid (dancing/ jiggling up and down or side to side) motion.	**Yes** ☐	**No** ■
Eye(s) are red and/or excessively mattered (beyond the usual sleep matter when the child first awakens or due to allergies).	**Yes** ☐	**No** ■
Eyelids are red, swollen, and/or are encrusted.	**Yes** ☐	**No** ■
An eyelid(s) is drooping or appears lower than the other.	**Yes** ☐	**No** ■

Behavior: Please report your observations of how your child uses vision in daily tasks. Answer yes or no the statements below. If you are unsure, leave the question blank for consultation from Part C or school district Child Find professionals with appropriate expertise.

Does your child ….

Consistently NOT make eye contact with familiar people (after two months of age).	**Yes** ■	**No** ☐
Cover or close an eye when looking at someone or something within close range (two feet or closer).	**Yes** ☐	**No** ■
Frown or squint an eye when looking at something far away (two feet or further).	**Yes** ☐	**No** ■
Tilt / turn head to the side, lift /lower chin, and/or thrust head forward or backward when looking at something at near or far range. *Circle which behavior occurs.*	**Yes** ☐	**No** ■
Close eyes or turns face away when listening to others talk.	**Yes** ■	**No** ☐
Does not smile in response to another person's smile.	**Yes** ☐	**No** ■
Hold an object very close to his or her eyes when looking at it.	**Yes** ☐	**No** ■
Stare at lights sources (overhead lights or windows) for a long period of time.	**Yes** ☐	**No** ■
Prefer certain colors; chooses items with these colors over items with other colors. (e.g., seems to look more intently at objects that are red.)	**Yes** ☐	**No** ■
Recognize familiar people only after they speak.	**Yes** ■	**No** ☐
Notice people, pets, or objects only when they are moving	**Yes** ☐	**No** ■
Seem to have inconsistent visual abilities (e.g. seems to change from morning to night or from day to day or between activities).	**Yes** ☐	**No** ■
Miss objects he or she is simultaneously looking at and reaching for (e.g. require multiple attempts to get the item).	**Yes** ☐	**No** ■
Look away when reaching toward a nearby object.	**Yes** ☐	**No** ■
Stumble frequently over objects that are in his or her path or bump into walls.	**Yes** ■	**No** ☐
Have difficulties detecting a change in floor surface, such as from tile to carpet. Hesitate or miss detecting step or a curb.	**Yes** ☐	**No** ■
Have trouble seeing small objects, such as a small piece of cereal left on tray / table.	**Yes** ☐	**No** ■
Lose interest quickly in games, projects or activities that require using his or her eyes for an extended period of time.	**Yes** ☐	**No** ■
Avoid looking at books, drawing, playing games or doing other projects that require focusing up close.	**Yes** ☐	**No** ■

Complaints: A young child will not usually "complain" about visual difficulties, but may show through behavior that something is not right with his or her vision. Answer yes or no the statements below. If you are unsure, leave the question blank for consultation from Part C or school district Child Find professionals with appropriate expertise.

Does your child ….

Appear to be overly sensitive to bright indoor lights or the sunlight. Squint excessively, put a hand over his eyes, or put his head down to avoid the light.	**Yes** ☐	**No** ■
Seem to have burning or itchy eyes, rub his or her eyes, rapidly blink, and/or have teary eyes not due to allergies.	**Yes** ☐	**No** ■
Rub his or her eyes or blink rapidly after looking at something (when he or she is not tired).	**Yes** ☐	**No** ■
Appear to only see an object when it's separated (isolated?) from other items (e.g. cannot find a specific toy when it's among other objects).	**Yes** ☐	**No** ■

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

None

Has your child ever been seen by an eye doctor (optometrist or ophthalmologist?) Yes ☐ No ■

If yes, what were the results of the exam? _____

Were glasses or another treatment prescribed? Yes ☐ No ☐

If yes, does your child wear the glasses, as prescribed? Yes ☐ No ☐

If not, what is the reason the child is not wearing his or her glasses:

Next Steps: Thank you for providing information about your child's vision. This information will be reviewed with your Part C or Child Find contact person to determine appropriate next steps.

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Child's Name: Ezequiel Montes **Child's DOB:** 6/28/19

Caregiver Name: _____ **Date:** _____

Community Center Board: _____ **District:** _____

Contact Person: _____ **Email:** _____

It is important to have information about possible vision concerns that may occur with other family members, as well as general medical information about your child.

General History: High Risk Populations for Visual Problems

Is there a family history of early onset vision loss (e.g., cataracts, albinism, etc.?)	**Yes** ■	**No** ☐
Is there a family history of eye crossing, color vision problems, and/or needing prescription glasses?	**Yes** ■	**No** ☐
Was your child exposed to any prenatal infections (e.g. toxoplasmosis, CMV)?	**Yes** ☐	**No** ■
Did your baby weigh fewer than three pounds at birth?	**Yes** ☐	**No** ■
Was your child born prematurely?	**Yes** ☐	**No** ■
Was your child exposed to alcohol or drugs before birth?	**Yes** ☐	**No** ■
Has your child had meningitis or encephalitis?	**Yes** ☐	**No** ■
Has your child experienced any form of brain injury / head trauma? (in utero stroke, brain hemorrhage, lack of oxygen, accidental or non-accidental trauma)	**Yes** ☐	**No** ■
Does your child have any neurological disorders (e.g. seizures, hydrocephaly)?	**Yes** ☐	**No** ■
Does your child have any difficulties with his or her hearing?	**Yes** ☐	**No** ■
Has your child been diagnosed with a syndrome (e.g. Down syndrome, CHARGE syndrome, etc.?)	**Yes** ☐	**No** ■
Has your child been diagnosed as having cerebral palsy?	**Yes** ☐	**No** ■

The ABCs of Early Vision Problems

Background Information: We can learn a lot about the health and well-being of a young child's vision by paying attention to the appearance of his or her eyes, visual behaviors, and complaints. Thank you for your assistance with this information to determine if there is a concern about your child's vision.

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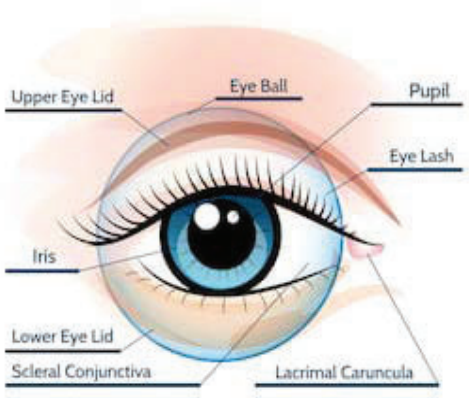

One eye looks different than the other eye. For example, one eye is significantly smaller in appearance or one eye is higher on the face than the other eye.	**Yes** ☐	**No** ☑
One or both eyes turn inward or outward. This can happen all of the time or only some of the time.	**Yes** ☐	**No** ■
There is 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** ☐	**No** ■
There is 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** ☐	**No** ■
One or both eyes appear white or cloudy.	**Yes** ☐	**No** ■
Eyes are in involuntary, rapid (dancing/ jiggling up and down or side to side) motion.	**Yes** ☐	**No** ■
Eye(s) are red and/or excessively mattered (beyond the usual sleep matter when the child first awakens or due to allergies).	**Yes** ☐	**No** ■
Eyelids are red, swollen, and/or are encrusted.	**Yes** ☐	**No** ■
An eyelid(s) is drooping or appears lower than the other.	**Yes** ☐	**No** ■

Behavior: Please report your observations of how your child uses vision in daily tasks. Answer yes or no the statements below. If you are unsure, leave the question blank for consultation from Part C or school district Child Find professionals with appropriate expertise.

Does your child ….

Consistently NOT make eye contact with familiar people (after two months of age).	**Yes** ☐	**No** ▣
Cover or close an eye when looking at someone or something within close range (two feet or closer).	**Yes** ☐	**No** ▣
Frown or squint an eye when looking at something far away (two feet or further).	**Yes** ☐	**No** ▣
Tilt / turn head to the side, lift /lower chin, and/or thrust head forward or backward when looking at something at near or far range. *Circle which behavior occurs.*	**Yes** ☐	**No** ▣
Close eyes or turns face away when listening to others talk.	**Yes** ☐	**No** ▣
Does not smile in response to another person's smile.	**Yes** ☐	**No** ▣
Hold an object very close to his or her eyes when looking at it.	**Yes** ☐	**No** ▣
Stare at lights sources (overhead lights or windows) for a long period of time.	**Yes** ☐	**No** ▣
Prefer certain colors; chooses items with these colors over items with other colors. (e.g., seems to look more intently at objects that are red.)	**Yes** ☐	**No** ▣
Recognize familiar people only after they speak.	**Yes** ☐	**No** ▣
Notice people, pets, or objects only when they are moving	**Yes** ☐	**No** ▣
Seem to have inconsistent visual abilities (e.g. seems to change from morning to night or from day to day or between activities).	**Yes** ☐	**No** ▣
Miss objects he or she is simultaneously looking at and reaching for (e.g. require multiple attempts to get the item).	**Yes** ☐	**No** ▣
Look away when reaching toward a nearby object.	**Yes** ☐	**No** ▣
Stumble frequently over objects that are in his or her path or bump into walls.	**Yes** ☐	**No** ▣
Have difficulties detecting a change in floor surface, such as from tile to carpet. Hesitate or miss detecting step or a curb.	**Yes** ☐	**No** ▣
Have trouble seeing small objects, such as a small piece of cereal left on tray / table.	**Yes** ☐	**No** ▣
Lose interest quickly in games, projects or activities that require using his or her eyes for an extended period of time.	**Yes** ☐	**No** ▣
Avoid looking at books, drawing, playing games or doing other projects that require focusing up close.	**Yes** ☐	**No** ▣

Complaints: A young child will not usually "complain" about visual difficulties, but may show through behavior that something is not right with his or her vision. Answer yes or no the statements below. If you are unsure, leave the question blank for consultation from Part C or school district Child Find professionals with appropriate expertise.

Does your child ….

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Seem to have burning or itchy eyes, rub his or her eyes, rapidly blink, and/or have teary eyes not due to allergies.	**Yes** ☐	**No** ■
Rub his or her eyes or blink rapidly after looking at something (when he or she is not tired).	**Yes** ■	**No** ☐
Appear to only see an object when it's separated (isolated?) from other items (e.g. cannot find a specific toy when it's among other objects).	**Yes** ☐	**No** ■

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

None

Has your child ever been seen by an eye doctor (optometrist or ophthalmologist?) Yes ☐ No ■

If yes, what were the results of the exam? _____

Were glasses or another treatment prescribed? Yes ☐ No ☐

If yes, does your child wear the glasses, as prescribed? Yes ☐ No ☐

If not, what is the reason the child is not wearing his or her glasses:

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Child's Name: Mya Reid **Child's DOB:** 8/15/18

Caregiver Name: _____ **Date:** _____

Community Center Board: _____ **District:** _____

Contact Person: _____ **Email:** _____

It is important to have information about possible vision concerns that may occur with other family members, as well as general medical information about your child.

General History: High Risk Populations for Visual Problems

Is there a family history of early onset vision loss (e.g., cataracts, albinism, etc.?)	Yes ☐	No ■
Is there a family history of eye crossing, color vision problems, and/or needing prescription glasses?	Yes ☐	No ■
Was your child exposed to any prenatal infections (e.g. toxoplasmosis, CMV)?	Yes ☐	No ■
Did your baby weigh fewer than three pounds at birth?	Yes ☐	No ■
Was your child born prematurely?	Yes ☐	No ■
Was your child exposed to alcohol or drugs before birth?	Yes ☐	No ■
Has your child had meningitis or encephalitis?	Yes ☐	No ■
Has your child experienced any form of brain injury / head trauma? (in utero stroke, brain hemorrhage, lack of oxygen, accidental or non-accidental trauma)	Yes ☐	No ■
Does your child have any neurological disorders (e.g. seizures, hydrocephaly)?	Yes ☐	No ■
Does your child have any difficulties with his or her hearing?	Yes ☐	No ■
Has your child been diagnosed with a syndrome (e.g. Down syndrome, CHARGE syndrome, etc.?)	Yes ☐	No ■
Has your child been diagnosed as having cerebral palsy?	Yes ☐	No ■

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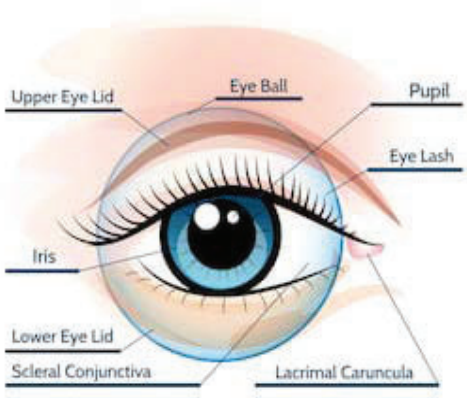
Appearance of the Eyes / Eyelids: Please take a few moments to observe the child eyes and eyelids. Answer yes or no the statements below. If you are unsure, leave the question blank for consultation from Part C or school district Child Find professionals with appropriate expertise.



One eye looks different than the other eye. For example, one eye is significantly smaller in appearance or one eye is higher on the face than the other eye.	**Yes** ☐	**No** ☑
One or both eyes turn inward or outward. This can happen all of the time or only some of the time.	**Yes** ☐	**No** ■
There is 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** ☐	**No** ■
There is 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** ☐	**No** ■
One or both eyes appear white or cloudy.	**Yes** ☐	**No** ■
Eyes are in involuntary, rapid (dancing/ jiggling up and down or side to side) motion. ABRUPT ONSET	**Yes** ■	**No** ☐
Eye(s) are red and/or excessively mattered (beyond the usual sleep matter when the child first awakens or due to allergies).	**Yes** ☐	**No** ■
Eyelids are red, swollen, and/or are encrusted.	**Yes** ☐	**No** ■
An eyelid(s) is drooping or appears lower than the other.	**Yes** ☐	**No** ■

Behavior: Please report your observations of how your child uses vision in daily tasks. Answer yes or no the statements below. If you are unsure, leave the question blank for consultation from Part C or school district Child Find professionals with appropriate expertise.

Does your child ….

Consistently NOT make eye contact with familiar people (after two months of age).	**Yes** ☐	**No** ▣
Cover or close an eye when looking at someone or something within close range (two feet or closer).	**Yes** ☐	**No** ▣
Frown or squint an eye when looking at something far away (two feet or further).	**Yes** ☐	**No** ▣
Tilt / turn head to the side, lift /lower chin, and/or thrust head forward or backward when looking at something at near or far range. *Circle which behavior occurs.*	**Yes** ☐	**No** ▣
Close eyes or turns face away when listening to others talk.	**Yes** ☐	**No** ▣
Does not smile in response to another person's smile.	**Yes** ☐	**No** ▣
Hold an object very close to his or her eyes when looking at it.	**Yes** ☐	**No** ▣
Stare at lights sources (overhead lights or windows) for a long period of time.	**Yes** ☐	**No** ▣
Prefer certain colors; chooses items with these colors over items with other colors. (e.g., seems to look more intently at objects that are red.)	**Yes** ☐	**No** ▣
Recognize familiar people only after they speak.	**Yes** ☐	**No** ▣
Notice people, pets, or objects only when they are moving	**Yes** ☐	**No** ▣
Seem to have inconsistent visual abilities (e.g. seems to change from morning to night or from day to day or between activities).	**Yes** ☐	**No** ▣
Miss objects he or she is simultaneously looking at and reaching for (e.g. require multiple attempts to get the item).	**Yes** ☐	**No** ▣
Look away when reaching toward a nearby object.	**Yes** ☐	**No** ▣
Stumble frequently over objects that are in his or her path or bump into walls.	**Yes** ☐	**No** ▣
Have difficulties detecting a change in floor surface, such as from tile to carpet. Hesitate or miss detecting step or a curb.	**Yes** ☐	**No** ▣
Have trouble seeing small objects, such as a small piece of cereal left on tray / table.	**Yes** ☐	**No** ▣
Lose interest quickly in games, projects or activities that require using his or her eyes for an extended period of time.	**Yes** ☐	**No** ▣
Avoid looking at books, drawing, playing games or doing other projects that require focusing up close.	**Yes** ☐	**No** ▣

Complaints: A young child will not usually "complain" about visual difficulties, but may show through behavior that something is not right with his or her vision. Answer yes or no the statements below. If you are unsure, leave the question blank for consultation from Part C or school district Child Find professionals with appropriate expertise.

Does your child ….

Appear to be overly sensitive to bright indoor lights or the sunlight. Squint excessively, put a hand over his eyes, or put his head down to avoid the light.	**Yes** ☐	**No** ■
Seem to have burning or itchy eyes, rub his or her eyes, rapidly blink, and/or have teary eyes not due to allergies.	**Yes** ☐	**No** ■
Rub his or her eyes or blink rapidly after looking at something (when he or she is not tired).	**Yes** ☐	**No** ■
Appear to only see an object when it's separated (isolated?) from other items (e.g. cannot find a specific toy when it's among other objects).	**Yes** ☐	**No** ■

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

None

Has your child ever been seen by an eye doctor (optometrist or ophthalmologist?) Yes ☐ No ■

If yes, what were the results of the exam? _____

Were glasses or another treatment prescribed? Yes ☐ No ☐

If yes, does your child wear the glasses, as prescribed? Yes ☐ No ☐

If not, what is the reason the child is not wearing his or her glasses:

Next Steps: Thank you for providing information about your child's vision. This information will be reviewed with your Part C or Child Find contact person to determine appropriate next steps.

References:

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

Teach CVI (2020). *Screening List for Children with a Suspicions of a Cerebral Visual Impairment CVI)* / *Screen List CVI 1* retrieved from https://f9d3e3e2-4dd0-4434-a4bb-27a978ad3a27.filesusr.com/ugd/eca85c_7ca670026a8d4f388c5d63828ec0610d.pdf

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.

COLORADO
Department of Education

Vision Screening Parent Questionnaire for Children Ages Birth through Five Years

This tool has been developed to address cursory vision screening practices for children ages birth through five years of age. It should be completed by a caregiver who knows the child best. The information will determine if there are vision concerns that warrant further evaluation when in-person screening or assessment activities can resume.

Child's Name: Kaylani Shaver **Child's DOB:** 6/26/18

Caregiver Name: _____ **Date:** _____

Community Center Board: _____ **District:** _____

Contact Person: _____ **Email:** _____

It is important to have information about possible vision concerns that may occur with other family members, as well as general medical information about your child.

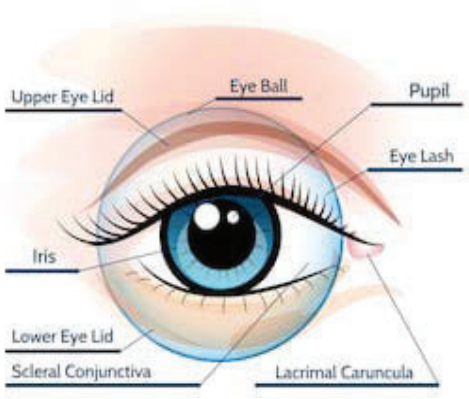
General History: High Risk Populations for Visual Problems

Is there a family history of early onset vision loss (e.g., cataracts, albinism, etc.?)	**Yes** ☐	**No** ■
Is there a family history of eye crossing, color vision problems, and/or needing prescription glasses?	**Yes** ☐	**No** ■
Was your child exposed to any prenatal infections (e.g. toxoplasmosis, CMV)?	**Yes** ☐	**No** ■
Did your baby weigh fewer than three pounds at birth?	**Yes** ☐	**No** ■
Was your child born prematurely?	**Yes** ☐	**No** ■
Was your child exposed to alcohol or drugs before birth?	**Yes** ☐	**No** ■
Has your child had meningitis or encephalitis?	**Yes** ☐	**No** ■
Has your child experienced any form of brain injury / head trauma? (in utero stroke, brain hemorrhage, lack of oxygen, accidental or non-accidental trauma)	**Yes** ☐	**No** ■
Does your child have any neurological disorders (e.g. seizures, hydrocephaly)?	**Yes** ☐	**No** ■
Does your child have any difficulties with his or her hearing?	**Yes** ☐	**No** ■
Has your child been diagnosed with a syndrome (e.g. Down syndrome, CHARGE syndrome, etc.?)	**Yes** ☐	**No** ■
Has your child been diagnosed as having cerebral palsy?	**Yes** ☐	**No** ■

The ABCs of Early Vision Problems

Background Information: We can learn a lot about the health and well-being of a young child's vision by paying attention to the appearance of his or her eyes, visual behaviors, and complaints. Thank you for your assistance with this information to determine if there is a concern about your child's vision.

Appearance of the Eyes / Eyelids: Please take a few moments to observe the child eyes and eyelids. Answer yes or no the statements below. If you are unsure, leave the question blank for consultation from Part C or school district Child Find professionals with appropriate expertise.



One eye looks different than the other eye. For example, one eye is significantly smaller in appearance or one eye is higher on the face than the other eye.	**Yes** ☐	**No** ☑
One or both eyes turn inward or outward. This can happen all of the time or only some of the time.	**Yes** ☐	**No** ■
There is 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** ☐	**No** ■
There is 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** ☐	**No** ■
One or both eyes appear white or cloudy.	**Yes** ☐	**No** ■
Eyes are in involuntary, rapid (dancing/ jiggling up and down or side to side) motion.	**Yes** ☐	**No** ■
Eye(s) are red and/or excessively mattered (beyond the usual sleep matter when the child first awakens or due to allergies).	**Yes** ☐	**No** ■
Eyelids are red, swollen, and/or are encrusted.	**Yes** ☐	**No** ■
An eyelid(s) is drooping or appears lower than the other.	**Yes** ☐	**No** ■

Behavior: Please report your observations of how your child uses vision in daily tasks. Answer yes or no the statements below. If you are unsure, leave the question blank for consultation from Part C or school district Child Find professionals with appropriate expertise.

Does your child ….

Consistently NOT make eye contact with familiar people (after two months of age).	**Yes** ☐	**No** ▣
Cover or close an eye when looking at someone or something within close range (two feet or closer).	**Yes** ☐	**No** ▣
Frown or squint an eye when looking at something far away (two feet or further).	**Yes** ☐	**No** ▣
Tilt / turn head to the side, lift /lower chin, and/or thrust head forward or backward when looking at something at near or far range. *Circle which behavior occurs.*	**Yes** ☐	**No** ▣
Close eyes or turns face away when listening to others talk.	**Yes** ☐	**No** ▣
Does not smile in response to another person's smile.	**Yes** ☐	**No** ▣
Hold an object very close to his or her eyes when looking at it.	**Yes** ☐	**No** ▣
Stare at lights sources (overhead lights or windows) for a long period of time.	**Yes** ☐	**No** ▣
Prefer certain colors; chooses items with these colors over items with other colors. (e.g., seems to look more intently at objects that are red.)	**Yes** ☐	**No** ▣
Recognize familiar people only after they speak.	**Yes** ☐	**No** ▣
Notice people, pets, or objects only when they are moving	**Yes** ☐	**No** ▣
Seem to have inconsistent visual abilities (e.g. seems to change from morning to night or from day to day or between activities).	**Yes** ☐	**No** ▣
Miss objects he or she is simultaneously looking at and reaching for (e.g. require multiple attempts to get the item).	**Yes** ☐	**No** ▣
Look away when reaching toward a nearby object.	**Yes** ☐	**No** ▣
Stumble frequently over objects that are in his or her path or bump into walls.	**Yes** ☐	**No** ▣
Have difficulties detecting a change in floor surface, such as from tile to carpet. Hesitate or miss detecting step or a curb.	**Yes** ☐	**No** ▣
Have trouble seeing small objects, such as a small piece of cereal left on tray / table.	**Yes** ☐	**No** ▣
Lose interest quickly in games, projects or activities that require using his or her eyes for an extended period of time.	**Yes** ☐	**No** ▣
Avoid looking at books, drawing, playing games or doing other projects that require focusing up close.	**Yes** ☐	**No** ▣

Complaints: A young child will not usually "complain" about visual difficulties, but may show through behavior that something is not right with his or her vision. Answer yes or no the statements below. If you are unsure, leave the question blank for consultation from Part C or school district Child Find professionals with appropriate expertise.

Does your child ….

Appear to be overly sensitive to bright indoor lights or the sunlight. Squint excessively, put a hand over his eyes, or put his head down to avoid the light.	**Yes** ☐	**No** ■
Seem to have burning or itchy eyes, rub his or her eyes, rapidly blink, and/or have teary eyes not due to allergies.	**Yes** ☐	**No** ■
Rub his or her eyes or blink rapidly after looking at something (when he or she is not tired).	**Yes** ☐	**No** ■
Appear to only see an object when it's separated (isolated?) from other items (e.g. cannot find a specific toy when it's among other objects).	**Yes** ☐	**No** ■

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

Yes, my child only looks briefly. She doesn't focus on me.

Has your child ever been seen by an eye doctor (optometrist or ophthalmologist?) Yes ☐ No ■

If yes, what were the results of the exam? _____

Were glasses or another treatment prescribed? Yes ☐ No ☐

If yes, does your child wear the glasses, as prescribed? Yes ☐ No ☐

If not, what is the reason the child is not wearing his or her glasses:

Next Steps: Thank you for providing information about your child's vision. This information will be reviewed with your Part C or Child Find contact person to determine appropriate next steps.

References:

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

Teach CVI (2020). *Screening List for Children with a Suspicions of a Cerebral Visual Impairment CVI)* / *Screen List CVI 1* retrieved from https://f9d3e3e2-4dd0-4434-a4bb-27a978ad3a27.filesusr.com/ugd/eca85c_7ca670026a8d4f388c5d63828ec0610d.pdf

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COLORADO
Department of Education

Vision Screening Parent Questionnaire for Children Ages Birth through Five Years

This tool has been developed to address cursory vision screening practices for children ages birth through five years of age. It should be completed by a caregiver who knows the child best. The information will determine if there are vision concerns that warrant further evaluation when in-person screening or assessment activities can resume.

Child's Name: Zoe Willis **Child's DOB:** 1/19/18

Caregiver Name: _____ **Date:** _____

Community Center Board: _____ **District:** _____

Contact Person: _____ **Email:** _____

It is important to have information about possible vision concerns that may occur with other family members, as well as general medical information about your child.

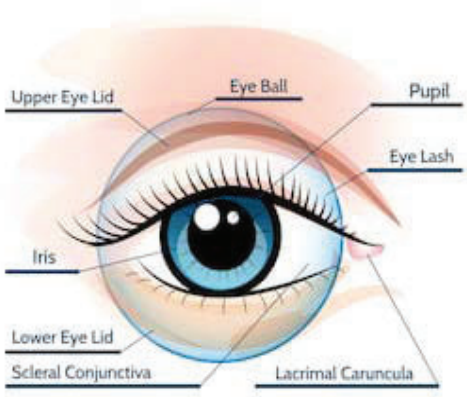
General History: High Risk Populations for Visual Problems

Is there a family history of early onset vision loss (e.g., cataracts, albinism, etc.?)	Yes ☐	No ■
Is there a family history of eye crossing, color vision problems, and/or needing prescription glasses?	Yes ■	No ☐
Was your child exposed to any prenatal infections (e.g. toxoplasmosis, CMV)?	Yes ☐	No ■
Did your baby weigh fewer than three pounds at birth?	Yes ☐	No ■
Was your child born prematurely?	Yes ☐	No ■
Was your child exposed to alcohol or drugs before birth?	Yes ☐	No ■
Has your child had meningitis or encephalitis?	Yes ☐	No ■
Has your child experienced any form of brain injury / head trauma? (in utero stroke, brain hemorrhage, lack of oxygen, accidental or non-accidental trauma)	Yes ☐	No ■
Does your child have any neurological disorders (e.g. seizures, hydrocephaly)?	Yes ☐	No ■
Does your child have any difficulties with his or her hearing?	Yes ☐	No ■
Has your child been diagnosed with a syndrome (e.g. Down syndrome, CHARGE syndrome, etc.?)	Yes ■	No ☐
Has your child been diagnosed as having cerebral palsy?	Yes ☐	No ■

The ABCs of Early Vision Problems

Background Information: We can learn a lot about the health and well-being of a young child's vision by paying attention to the appearance of his or her eyes, visual behaviors, and complaints. Thank you for your assistance with this information to determine if there is a concern about your child's vision.

Appearance of the Eyes / Eyelids: Please take a few moments to observe the child eyes and eyelids. Answer yes or no the statements below. If you are unsure, leave the question blank for consultation from Part C or school district Child Find professionals with appropriate expertise.



One eye looks different than the other eye. For example, one eye is significantly smaller in appearance or one eye is higher on the face than the other eye.	**Yes** ☐	**No** ☑
One or both eyes turn inward or outward. This can happen all of the time or only some of the time.	**Yes** ☐	**No** ■
There is 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** ☐	**No** ■
There is 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** ☐	**No** ■
One or both eyes appear white or cloudy.	**Yes** ☐	**No** ■
Eyes are in involuntary, rapid (dancing/ jiggling up and down or side to side) motion.	**Yes** ☐	**No** ■
Eye(s) are red and/or excessively mattered (beyond the usual sleep matter when the child first awakens or due to allergies).	**Yes** ☐	**No** ■
Eyelids are red, swollen, and/or are encrusted.	**Yes** ☐	**No** ■
An eyelid(s) is drooping or appears lower than the other.	**Yes** ☐	**No** ■

Behavior: Please report your observations of how your child uses vision in daily tasks. Answer yes or no the statements below. If you are unsure, leave the question blank for consultation from Part C or school district Child Find professionals with appropriate expertise.

Does your child ….

Consistently NOT make eye contact with familiar people (after two months of age).	**Yes** ☐	**No** ▣
Cover or close an eye when looking at someone or something within close range (two feet or closer).	**Yes** ☐	**No** ▣
Frown or squint an eye when looking at something far away (two feet or further).	**Yes** ☐	**No** ▣
Tilt / turn head to the side, lift /lower chin, and/or thrust head forward or backward when looking at something at near or far range. *Circle which behavior occurs.*	**Yes** ☐	**No** ▣
Close eyes or turns face away when listening to others talk.	**Yes** ☐	**No** ▣
Does not smile in response to another person's smile.	**Yes** ☐	**No** ▣
Hold an object very close to his or her eyes when looking at it.	**Yes** ☐	**No** ▣
Stare at lights sources (overhead lights or windows) for a long period of time.	**Yes** ☐	**No** ▣
Prefer certain colors; chooses items with these colors over items with other colors. (e.g., seems to look more intently at objects that are red.)	**Yes** ☐	**No** ▣
Recognize familiar people only after they speak.	**Yes** ☐	**No** ▣
Notice people, pets, or objects only when they are moving	**Yes** ☐	**No** ▣
Seem to have inconsistent visual abilities (e.g. seems to change from morning to night or from day to day or between activities).	**Yes** ☐	**No** ▣
Miss objects he or she is simultaneously looking at and reaching for (e.g. require multiple attempts to get the item).	**Yes** ☐	**No** ▣
Look away when reaching toward a nearby object.	**Yes** ☐	**No** ▣
Stumble frequently over objects that are in his or her path or bump into walls.	**Yes** ☐	**No** ▣
Have difficulties detecting a change in floor surface, such as from tile to carpet. Hesitate or miss detecting step or a curb.	**Yes** ☐	**No** ▣
Have trouble seeing small objects, such as a small piece of cereal left on tray / table.	**Yes** ▣	**No** ☐
Lose interest quickly in games, projects or activities that require using his or her eyes for an extended period of time.	**Yes** ☐	**No** ▣
Avoid looking at books, drawing, playing games or doing other projects that require focusing up close.	**Yes** ☐	**No** ▣

Complaints: A young child will not usually "complain" about visual difficulties, but may show through behavior that something is not right with his or her vision. Answer yes or no the statements below. If you are unsure, leave the question blank for consultation from Part C or school district Child Find professionals with appropriate expertise.

Does your child ….

Appear to be overly sensitive to bright indoor lights or the sunlight. Squint excessively, put a hand over his eyes, or put his head down to avoid the light.	**Yes** ☐	**No** ■
Seem to have burning or itchy eyes, rub his or her eyes, rapidly blink, and/or have teary eyes not due to allergies.	**Yes** ☐	**No** ■
Rub his or her eyes or blink rapidly after looking at something (when he or she is not tired).	**Yes** ☐	**No** ■
Appear to only see an object when it's separated (isolated?) from other items (e.g. cannot find a specific toy when it's among other objects).	**Yes** ☐	**No** ■

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

None

Has your child ever been seen by an eye doctor (optometrist or ophthalmologist?) Yes ■ No ☐

If yes, what were the results of the exam? Poor vision

Were glasses or another treatment prescribed? Yes ■ No ☐

If yes, does your child wear the glasses, as prescribed? Yes ■ No ☐

If not, what is the reason the child is not wearing his or her glasses:

Next Steps: Thank you for providing information about your child's vision. This information will be reviewed with your Part C or Child Find contact person to determine appropriate next steps.

References:

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

Teach CVI (2020). *Screening List for Children with a Suspicions of a Cerebral Visual Impairment CVI)* / *Screen List CVI 1* retrieved from https://f9d3e3e2-4dd0-4434-a4bb-27a978ad3a27.filesusr.com/ugd/eca85c_7ca670026a8d4f388c5d63828ec0610d.pdf

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