



**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: 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.

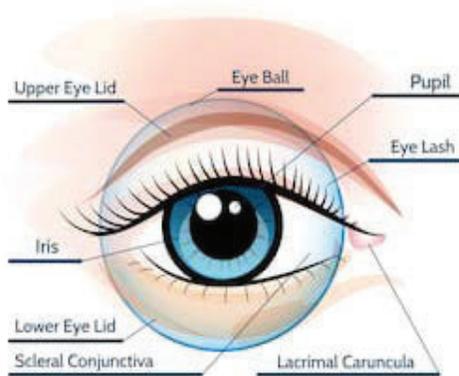
**General History: High Risk Populations for Visual Problems**

- 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 matterred (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 to 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 <input checked="" type="checkbox"/> | No <input type="checkbox"/>            |
| Cover or close an eye when looking at someone or something within close range (two feet or closer).   | Yes <input type="checkbox"/>            | No <input checked="" type="checkbox"/> |
| Frown or squint an eye when looking at something far away (two feet or further).  | Yes <input type="checkbox"/>            | No <input checked="" type="checkbox"/> |
| 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. <i>Circle which behavior occurs.</i> | Yes <input type="checkbox"/>            | No <input checked="" type="checkbox"/> |
| Close eyes or turns face away when listening to others talk.  | Yes <input checked="" type="checkbox"/> | No <input type="checkbox"/>            |
| Does not smile in response to another person's smile.   | Yes <input type="checkbox"/>            | No <input checked="" type="checkbox"/> |
| Hold an object very close to his or her eyes when looking at it.  | Yes <input type="checkbox"/>            | No <input checked="" type="checkbox"/> |
| Stare at lights sources (overhead lights or windows) for a long period of time.   | Yes <input type="checkbox"/>            | No <input checked="" type="checkbox"/> |
| 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 <input type="checkbox"/>            | No <input checked="" type="checkbox"/> |
| Recognize familiar people only <u>after</u> they speak.   | Yes <input checked="" type="checkbox"/> | No <input type="checkbox"/>            |
| Notice people, pets, or objects only when they are moving   | Yes <input type="checkbox"/>            | No <input checked="" type="checkbox"/> |
| Seem to have inconsistent visual abilities (e.g. seems to change from morning to night or from day to day or between activities).   | Yes <input type="checkbox"/>            | No <input checked="" type="checkbox"/> |
| Miss objects he or she is simultaneously looking at and reaching for (e.g. require multiple attempts to get the item).  | Yes <input type="checkbox"/>            | No <input checked="" type="checkbox"/> |
| Look away when reaching toward a nearby object.   | Yes <input type="checkbox"/>            | No <input checked="" type="checkbox"/> |
| Stumble frequently over objects that are in his or her path or bump into walls.   | Yes <input checked="" type="checkbox"/> | No <input type="checkbox"/>            |
| Have difficulties detecting a change in floor surface, such as from tile to carpet. Hesitate or miss detecting step or a curb.  | Yes <input type="checkbox"/>            | No <input checked="" type="checkbox"/> |
| Have trouble seeing small objects, such as a small piece of cereal left on tray / table.  | Yes <input type="checkbox"/>            | No <input checked="" type="checkbox"/> |
| Lose interest quickly in games, projects or activities that require using his or her eyes for an extended period of time.   | Yes <input type="checkbox"/>            | No <input checked="" type="checkbox"/> |
| Avoid looking at books, drawing, playing games or doing other projects that require focusing up close.  | Yes <input type="checkbox"/>            | No <input checked="" type="checkbox"/> |

**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

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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: 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.

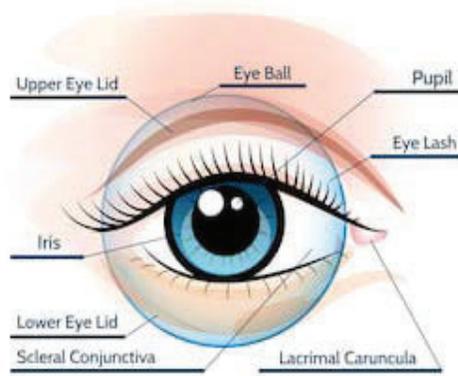
**General History: High Risk Populations for Visual Problems**

- 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

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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 to 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 <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Cover or close an eye when looking at someone or something within close range (two feet or closer).   | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Frown or squint an eye when looking at something far away (two feet or further).  | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| 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. <i>Circle which behavior occurs.</i> | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Close eyes or turns face away when listening to others talk.  | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Does not smile in response to another person's smile.   | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Hold an object very close to his or her eyes when looking at it.  | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Stare at lights sources (overhead lights or windows) for a long period of time.   | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| 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 <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Recognize familiar people only <u>after</u> they speak.   | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Notice people, pets, or objects only when they are moving   | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Seem to have inconsistent visual abilities (e.g. seems to change from morning to night or from day to day or between activities).   | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Miss objects he or she is simultaneously looking at and reaching for (e.g. require multiple attempts to get the item).  | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Look away when reaching toward a nearby object.   | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Stumble frequently over objects that are in his or her path or bump into walls.   | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Have difficulties detecting a change in floor surface, such as from tile to carpet. Hesitate or miss detecting step or a curb.  | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Have trouble seeing small objects, such as a small piece of cereal left on tray / table.  | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Lose interest quickly in games, projects or activities that require using his or her eyes for an extended period of time.   | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Avoid looking at books, drawing, playing games or doing other projects that require focusing up close.  | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |

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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

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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.

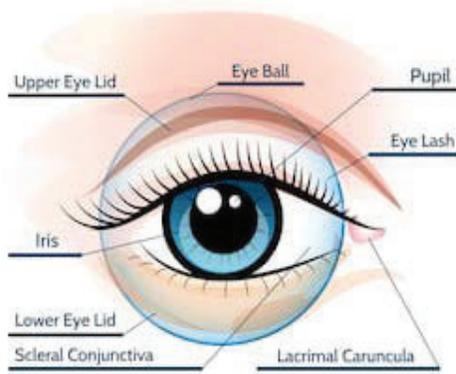
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- Did your baby weigh fewer than three pounds at birth? Yes  No
- Was your child born prematurely? Yes  No
- Was your child exposed to alcohol or drugs before birth? Yes  No
- Has your child had meningitis or encephalitis? Yes  No
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- 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
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Yes  No

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Yes  No

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Yes  No

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Yes  No

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Yes  No

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Yes  No

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Yes  No

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An eyelid(s) is drooping or appears lower than the other.

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**Behavior:** Please report your observations of how your child uses vision in daily tasks. Answer yes or no to 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.

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- |   |                              |  |
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| Hold an object very close to his or her eyes when looking at it.  | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
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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

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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.

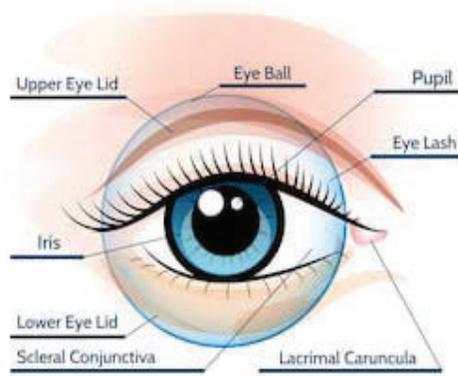
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- |   |                              |  |
|---|------------------------------|--|
| Is there a family history of early onset vision loss (e.g., cataracts, albinism, etc.?)   | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Is there a family history of eye crossing, color vision problems, and/or needing prescription glasses?  | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Was your child exposed to any prenatal infections (e.g. toxoplasmosis, CMV)?  | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Did your baby weigh fewer than three pounds at birth?   | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Was your child born prematurely?  | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Was your child exposed to alcohol or drugs before birth?  | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Has your child had meningitis or encephalitis?  | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| 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 <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Does your child have any neurological disorders (e.g. seizures, hydrocephaly)?  | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Does your child have any difficulties with his or her hearing?  | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Has your child been diagnosed with a syndrome (e.g. Down syndrome, CHARGE syndrome, etc.?)  | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Has your child been diagnosed as having cerebral palsy?   | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |

## 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 <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| One or both eyes turn inward or outward. This can happen all of the time or only some of the time.   | Yes <input type="checkbox"/> | No <input type="checkbox"/>            |
| 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 <input type="checkbox"/> | No <input type="checkbox"/>            |
| 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 <input type="checkbox"/> | No <input type="checkbox"/>            |
| One or both eyes appear white or cloudy.   | Yes <input type="checkbox"/> | No <input type="checkbox"/>            |
| Eyes are in involuntary, rapid (dancing/ jiggling up and down or side to side) motion.   | Yes <input type="checkbox"/> | No <input type="checkbox"/>            |
| Eye(s) are 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 type="checkbox"/>            |
| Eyelids are red, swollen, and/or are encrusted.  | Yes <input type="checkbox"/> | No <input type="checkbox"/>            |
| An eyelid(s) is drooping or appears lower than the other.  | Yes <input type="checkbox"/> | No <input type="checkbox"/>            |

ABRUPT ONSET

**Behavior:** Please report your observations of how your child uses vision in daily tasks. Answer yes or no to 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 <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Cover or close an eye when looking at someone or something within close range (two feet or closer).   | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Frown or squint an eye when looking at something far away (two feet or further).  | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| 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. <i>Circle which behavior occurs.</i> | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Close eyes or turns face away when listening to others talk.  | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Does not smile in response to another person's smile.   | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Hold an object very close to his or her eyes when looking at it.  | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Stare at lights sources (overhead lights or windows) for a long period of time.   | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| 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 <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Recognize familiar people only <u>after</u> they speak.   | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Notice people, pets, or objects only when they are moving   | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Seem to have inconsistent visual abilities (e.g. seems to change from morning to night or from day to day or between activities).   | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Miss objects he or she is simultaneously looking at and reaching for (e.g. require multiple attempts to get the item).  | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Look away when reaching toward a nearby object.   | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Stumble frequently over objects that are in his or her path or bump into walls.   | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Have difficulties detecting a change in floor surface, such as from tile to carpet. Hesitate or miss detecting step or a curb.  | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Have trouble seeing small objects, such as a small piece of cereal left on tray / table.  | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Lose interest quickly in games, projects or activities that require using his or her eyes for an extended period of time.   | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Avoid looking at books, drawing, playing games or doing other projects that require focusing up close.  | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |

**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

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---

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 Suspicious of a Cerebral Visual Impairment CVI](https://f9d3e3e2-4dd0-4434-a4bb-27a978ad3a27.filesusr.com/ugd/eca85c_7ca670026a8d4f388c5d63828ec0610d.pdf) / Screen List CVI 1 retrieved from [https://f9d3e3e2-4dd0-4434-a4bb-27a978ad3a27.filesusr.com/ugd/eca85c\\_7ca670026a8d4f388c5d63828ec0610d.pdf](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**  
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**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.

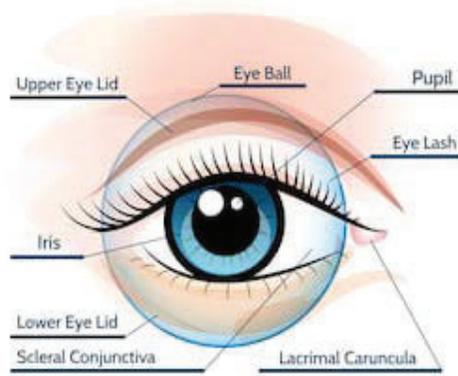
**General History: High Risk Populations for Visual Problems**

- 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 to 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 <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Cover or close an eye when looking at someone or something within close range (two feet or closer).   | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Frown or squint an eye when looking at something far away (two feet or further).  | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| 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. <i>Circle which behavior occurs.</i> | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Close eyes or turns face away when listening to others talk.  | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Does not smile in response to another person's smile.   | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Hold an object very close to his or her eyes when looking at it.  | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Stare at lights sources (overhead lights or windows) for a long period of time.   | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| 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 <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Recognize familiar people only <u>after</u> they speak.   | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Notice people, pets, or objects only when they are moving   | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Seem to have inconsistent visual abilities (e.g. seems to change from morning to night or from day to day or between activities).   | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Miss objects he or she is simultaneously looking at and reaching for (e.g. require multiple attempts to get the item).  | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Look away when reaching toward a nearby object.   | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Stumble frequently over objects that are in his or her path or bump into walls.   | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Have difficulties detecting a change in floor surface, such as from tile to carpet. Hesitate or miss detecting step or a curb.  | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Have trouble seeing small objects, such as a small piece of cereal left on tray / table.  | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Lose interest quickly in games, projects or activities that require using his or her eyes for an extended period of time.   | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Avoid looking at books, drawing, playing games or doing other projects that require focusing up close.  | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |

**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 Suspicious of a Cerebral Visual Impairment CVI](https://f9d3e3e2-4dd0-4434-a4bb-27a978ad3a27.filesusr.com/ugd/eca85c_7ca670026a8d4f388c5d63828ec0610d.pdf) / Screen List CVI 1 retrieved from [https://f9d3e3e2-4dd0-4434-a4bb-27a978ad3a27.filesusr.com/ugd/eca85c\\_7ca670026a8d4f388c5d63828ec0610d.pdf](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.



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**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.

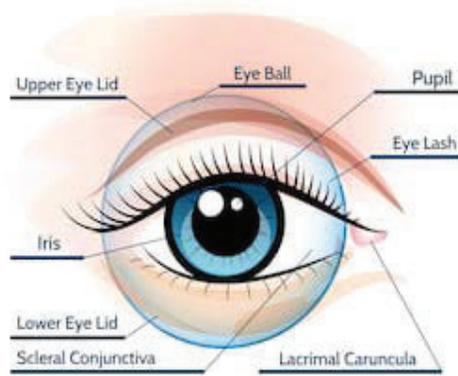
**General History: High Risk Populations for Visual Problems**

- 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 to 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 <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Cover or close an eye when looking at someone or something within close range (two feet or closer).   | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Frown or squint an eye when looking at something far away (two feet or further).  | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| 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. <i>Circle which behavior occurs.</i> | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Close eyes or turns face away when listening to others talk.  | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Does not smile in response to another person's smile.   | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Hold an object very close to his or her eyes when looking at it.  | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Stare at lights sources (overhead lights or windows) for a long period of time.   | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| 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 <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Recognize familiar people only <u>after</u> they speak.   | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Notice people, pets, or objects only when they are moving   | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Seem to have inconsistent visual abilities (e.g. seems to change from morning to night or from day to day or between activities).   | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Miss objects he or she is simultaneously looking at and reaching for (e.g. require multiple attempts to get the item).  | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Look away when reaching toward a nearby object.   | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Stumble frequently over objects that are in his or her path or bump into walls.   | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Have difficulties detecting a change in floor surface, such as from tile to carpet. Hesitate or miss detecting step or a curb.  | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Have trouble seeing small objects, such as a small piece of cereal left on tray / table.  | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Lose interest quickly in games, projects or activities that require using his or her eyes for an extended period of time.   | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Avoid looking at books, drawing, playing games or doing other projects that require focusing up close.  | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |

**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

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---

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

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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 Suspicious of a Cerebral Visual Impairment CVI](https://f9d3e3e2-4dd0-4434-a4bb-27a978ad3a27.filesusr.com/ugd/eca85c_7ca670026a8d4f388c5d63828ec0610d.pdf) / Screen List CVI 1 retrieved from [https://f9d3e3e2-4dd0-4434-a4bb-27a978ad3a27.filesusr.com/ugd/eca85c\\_7ca670026a8d4f388c5d63828ec0610d.pdf](https://f9d3e3e2-4dd0-4434-a4bb-27a978ad3a27.filesusr.com/ugd/eca85c_7ca670026a8d4f388c5d63828ec0610d.pdf)

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