



Vision Screening – Birth to Age 3
Scoring the
Parent Questionnaire

PARENT QUESTIONNAIRE
PRACTICE 4 – JIMENA SILVA
(Please print prior to training session)



Vision Screening Parent Questionnaire for Children Birth to Age Three

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

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

Family Vision History (Parents and Siblings)

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

Child’s Medical History

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

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

Eye Doctor Examination

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

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

Appearance of Eyes and Eyelids

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

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

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

Behaviors

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

My child...

Answer the following statement for children one month or older

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

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

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

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

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

Caregiver Concerns

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

Next Steps:

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

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

EI Evaluation

IFSP (initial, annual, periodic review)

Other

References:

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

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

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



Vision Screening - Birth to Age 3 Vision Screening Parent Questionnaire (Updated 2022) Scoring Guidance

Child's Name:		DOB:	
Evaluator Name:		Today's Date:	

INTRODUCTION

The screening process is designed to answer one simple question, **“Is there a vision concern that requires further examination by a pediatric eye doctor?”**

The information collected in the Vision Screening Parent Questionnaire is important in helping to identify children who may require further evaluation. Screeners are looking for both ocular and neurological indications of vision concerns. The questionnaire is not intended to diagnose medical conditions. It is not a comprehensive assessment or a guide for educational programming.

The questionnaire and scoring should take about 10 minutes to complete by a qualified, experienced professional.

Successful completion of vision screening training is required before using this “Vision Screening Parent Questionnaire – Scoring Guidance.” Contact A Shared Vision for training or support.

Note, if a child is currently receiving early intervention vision services from an Early Intervention Teacher of the Visually Impaired (EI-TV), then you do not need to complete this screening process.

RECOMMENDED PROCESS

1.	2.	3.	4.	5.	6.	7.
Send or give “Parent Questionnaire” to caregivers to complete before meeting.	Score “Parent Questionnaire” Clarify caregivers’ responses, if needed.	Fill out “Results and Next Steps for Caregivers.” Give form to caregivers.	Help caregivers understand telehealth vs. in-person visits with pediatric eye doctor.	Provide other valuable information to caregivers.	Request the eye doctor’s report, if appropriate, and place in child’s file.	Place copy of completed “Parent Questionnaire” and “Next Steps” in file.

AS YOU'RE GETTING STARTED WITH THE VISION SCREENING PROCESS

Under certain circumstances an **urgent** recommendation for follow up with a pediatric ophthalmologist is highly recommended. These include:

- One eye looks different than the other eye (e.g., one eye is significantly smaller in appearance, or one eye is higher on the face than the other eye).
- One or both eyes turn inward or outward. This can happen all of the time or only some of the time. **This is urgent if abrupt onset for a child 2-3 years old.**
- There is a difference in the black color, size, or shape of the pupils in one or both eyes. **This is urgent if the size of the unequal pupil is more than one millimeter.**
- There is a difference in the size or shape of the iris in one or both eyes. **This is urgent if the size of the unequal iris is more than one millimeter.**
- One of both eyes appear cloudy or white.
- Eye movement is involuntary, with rapid (dancing/ jiggling up and down or side to side) motion. **This is urgent if abrupt onset.**

If any of these circumstances exist, complete review of the questionnaire, and then instruct the caregivers to call a pediatric ophthalmologist within 1 to 2 days. The information gathered in the questionnaire will provide important documentation for the pediatric eye doctor and EI-TVI.

SCORING INSTRUCTIONS

Family Vision History (Parents and Siblings)

If there are **one or more** positive responses ("yes"), select Concerns Identified.

<input type="checkbox"/>	No Concerns
<input type="checkbox"/>	Concerns Identified: Child is at higher risk for visual impairment.

Child's Medical History

If there are **one or more** positive responses ("yes"), select Concerns Identified.

<input type="checkbox"/>	No Concerns
<input type="checkbox"/>	Concerns Identified: Child is at higher risk for visual impairment.

Eye Doctor Examination

This information is not scored. However, if an eye report is available, please request the form to add to the child's file.

Appearance of Eyes and Eyelids

If there are **one or more** positive responses (“yes”), select either Non-urgent or Urgent Concerns Identified.

<input type="checkbox"/>	No Concerns
<input type="checkbox"/>	Non-urgent Concerns Identified: Recommend follow up with pediatric ophthalmologist or pediatric optometrist.
<input type="checkbox"/>	Urgent Concerns Identified: Recommend follow up with pediatric ophthalmologist.

Objective Test

If there are **one or more** positive responses (“yes”), select Concerns Identified.

<input type="checkbox"/>	No Concerns
<input type="checkbox"/>	Concerns: Recommend follow up with pediatric ophthalmologist or pediatric optometrist.

Behaviors – automatic referral if “yes” answer to any of questions 1-5

If there are **one or more** positive responses (“yes”), select Concerns Identified.

<input type="checkbox"/>	No Concerns
<input type="checkbox"/>	Concerns Identified: Recommend follow up with pediatric ophthalmologist to discuss possible neurological visual impairment.

Behaviors – referral if two or more “yes” answers to questions 1-18

If there are **TWO or more** positive responses (“yes”), select Concerns Identified.

<input type="checkbox"/>	No Concerns: If one or no “yes” answers to questions 1 thru 18, then no concerns.
<input type="checkbox"/>	Concerns Identified: Recommend follow with pediatric ophthalmologist if two or more “yes” answers to questions 1 thru 18 to discuss possible neurological visual impairment.

Caregiver Concerns

If there are **one or more** positive responses (“yes”), select Concerns Identified.

<input type="checkbox"/>	No Concerns
<input type="checkbox"/>	Concerns Identified: If child is enrolled in early intervention, then consider adding vision services on IFSP for EI-TVVI to discuss concerns with caregiver. Otherwise, refer family to pediatrician or other PCP doctor.

WRAP-UP

1. Fill out the “Vision Screening Results & Next Steps for Caregivers” form.
2. Provide caregivers with a copy of the completed form and review action plan.
3. If a recommendation for follow up with an eye doctor is suggested and child has been seen by an eye doctor, then request the eye doctor’s report to place in the child’s file.



Vision Screening for Children Birth to Age Three Results Summary and Referral Recommendations Rubric

Place an “X” in the appropriate column for each section of the Vision Screening protocol to determine appropriate referral and next steps.

Screening Component	No Concerns	Concerns Identified	Next Steps Recommendation(s)
Family Vision History	<input type="checkbox"/>	<input type="checkbox"/>	No referral – If no other concerns are identified, indicate “No observable vision problems. However some risk factors exist.”
Child’s Medical History	<input type="checkbox"/>	<input type="checkbox"/>	
Appearance of Eyes and Eyelids (non-urgent)	<input type="checkbox"/>	<input type="checkbox"/>	Refer – recommend non-urgent follow up with a pediatric ophthalmologist or optometrist. (Consider vision services on IFSP.)
Appearance of Eyes and Eyelids (urgent)		<input type="checkbox"/>	Refer – recommend URGENT follow up with a pediatric ophthalmologist. (Consider vision services on IFSP.)
Objective Testing (fixation, visual tracking, pupillary reflex, corneal light reflection, instrument-based screening)	<input type="checkbox"/>	<input type="checkbox"/>	Refer – recommend non-urgent follow up with a pediatric ophthalmologist or optometrist. (Consider vision services on IFSP.)
Behaviors (1-5)	<input type="checkbox"/>	<input type="checkbox"/>	Refer – recommend non-urgent follow up with a pediatric ophthalmologist. (Consider vision services on IFSP.)
Behaviors (two+ 1-18)	<input type="checkbox"/>	<input type="checkbox"/>	
Caregiver Concerns	<input type="checkbox"/>	<input type="checkbox"/>	Refer – If child is enrolled in early intervention, then consider vision services on IFSP for EI-TVI to discuss concerns with caregiver. Otherwise, refer family to pediatrician or other PCP doctor.

Contact Information for Pediatric Ophthalmologists and Optometrists

See list of pediatric eye doctors at <https://www.asharedvision.org/pediatric-eye-doctors-in-colorado.html>



Vision Screening – Birth to Age 3 Vision Screening Results & Recommend Next Steps for Caregivers

Screening Professional:		Screening Date:	
Child's Name:		DOB:	

Screening Results and Recommended Next Steps

<input type="checkbox"/>	<p>No further action required at this time. Rescreen annually or sooner if any concerns arise.</p>
<input type="checkbox"/>	<p>No observable vision problems. However, some risk factors are present, e.g., family history and/or medical risk factors.</p> <ul style="list-style-type: none"> • Provide developmental milestones specific to vision to caregivers for reference. • If concerns arise, discuss with a pediatric ophthalmologist, optometrist, or PCP. • Rescreen annually.
<input type="checkbox"/>	<p>Vision concerns are observed.</p> <ul style="list-style-type: none"> • Describe vision concerns (use the back of this page if more room is needed): _____ • Recommend contacting a pediatric ophthalmologist or optometrist for follow-up. • Consider support from an Early Intervention Teacher of the Visually Impaired.
<input type="checkbox"/>	<p>Urgent vision concerns are observed.</p> <ul style="list-style-type: none"> • Describe vision concerns (use the back of this page if more room is needed): _____ • Recommend contacting a pediatric ophthalmologist for immediate follow-up. • Consider support from an Early Intervention Teacher of the Visually Impaired.

Provide this document to caregivers at the conclusion of vision screening.