

Comfortable vision,
healthy eyes!

The following questions are for children 12 years or younger.

Visual Behavior

- Writing Does the child write always on the line? Yes No
- reverse letters? (For example writing a "b" instead of "d") Yes No
- mix up letters? (For example "teh" instead of "the") Yes No
- Reading Does the child like to read? Yes No
- use his/her finger when reading to stay in place? Yes No
- go to the wrong line when finished reading a line? Yes No
- tilt or turn the head when reading? Yes No
- squint when reading? Yes No
- frown when reading? Yes No
- rub his/her eyes during or after reading? Yes No
- eyes tear during or after reading? Yes No
- eyes red after reading? Yes No
- tired after reading? Yes No
- Speech/Hearing Does the child speak clearly for his/her age? Yes No
- understand words appropriate for his/her age? Yes No

Other How far away does the child sit when watching TV? _____ ft

Do you have any concerns about the child's vision? Please describe below:

Development

- Age: years _____ months _____ Birth Weight _____ Premature _____ weeks early Fullterm
- APGAR score _____ Problems during birth _____ None
- Development Delayed / Late _____ Normal
- Any severe illness _____ None

Pediatrician

Does not have a pediatrician

Name _____ Clinic _____

Address _____

City _____ State _____ Zip _____ Telephone _____

School Information

School _____ City _____

Teacher _____ School Nurse _____

Grade _____ Receives Special Instructions _____ No

Subject favorite _____ Least favorite _____

Is the child's achievement compared to his/her class average Below Above Average

I would like that the teacher and school nurse is informed in writing about the vision of my child. No Yes

Signature _____ Date _____ until revoked

Relationship Parent Legal Guardian POA other _____