

Teacher and Child Vision Pre-Screening Worksheet

Purpose:

To identify eye or vision problems throughout the year.

Procedure:

Child is asked to report any complaint about his/her eyes. Teachers are asked to report any abnormal visual behaviors, or any visual complaints as expressed by the child whenever they occur and give report prior to screening.

Child's Name: _____ Grade _____ DOB/Age: _____/_____

Teacher's Name: _____ Date Completed _____

Other Comments _____

Teacher's Observations (Circle Yes or No as indicated)	YES	NO
Do you suspect anything is wrong with the child's eye(s)/vision	YES	NO
Has the child ever been diagnosed with an eye condition that you are aware of	YES	NO
Have you observed any problems or change in the whites, pupils, lids, lashes, or the area around the eyes	YES	NO
Has the child shown any signs of abnormal sensitivity to light or dizziness	YES	NO
Abnormally short attention span	YES	NO
Turning of one eye (in, out, up, or down)	YES	NO
Poking at the eyes or frequent rubbing	YES	NO
Excessive blinking	YES	NO
Unusual watering or discharge of the eye(s)	YES	NO
Poor eye contact or eye-hand coordination	YES	NO
Covering or closing an eye when looking at an item of interest	YES	NO
Abnormal head posture such as tilting the head to one side or moving forward or backward when viewing an item of interest	YES	NO
Squinting	YES	NO
Placing the head close to an item of interest	YES	NO
Inaccuracy in reaching for an item of interest	YES	NO
Avoiding close work	YES	NO
Frowning or scowl when reading	YES	NO
Using finger or other device to keep place while reading	YES	NO
Child's performance in school is less than expected	YES	NO

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Child's Complaints:	YES	NO
Light Sensitivity	YES	NO
Burning or itching of eyes or lids	YES	NO
Blurred vision or seeing double images	YES	NO
Words or lines running together	YES	NO
Words or pictures jumping	YES	NO
Headache	YES	NO
Nausea or dizziness	YES	NO

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01/2022

To obtain this information in a different format, call: 651-201-3650.