Developed by the Early Childhood Vision Professionals Team, Parent Outreach Program for the Visually Impaired
Arizona State Schools for the Deaf and the Blind

VISION SCREENING CHECKLIST

NOTE TO SCREENERS AND PARENTS:

This screening was developed to use with infants, toddlers and young children who cannot participate in an acuity screening.
When a child can match, select, identify or name a picture or symbol that is the same as the one the screener is showing to the child, one of the formal acuity screenings designed for early learners should be given as a supplement to this checklist screening.

CHILD'S NAME: _____

Child's Date of Birth: _____ **Chronological age** (age at the time of the screening): _____

Adjusted age (for prematurely born children now under two years, subtract # of weeks of prematurity from the chronological age): _____

Person(s) completing the checklist with the child's parent or caregiver: 1. _____ 2. _____ *(parent /caregiver)* 3. _____ 4. _____

(Please write your role on the child's team or your agency after your name)

Checklist completed on (DATE): _____

SCREENERS: Completed screenings with indicators checked require a family copy to share with health care provider – see *Note below

If your child has not seen an eye doctor yet, completing this screening will give you an indication of possible concerns or signs to watch for.
If your child has already seen an eye doctor, completing this screening will tell more about how your child uses vision.
THERE IS NO SCREENING THAT WILL SUBSTITUTE FOR AN EYE EXAM BY A PEDIATRIC EYE DOCTOR.

Has the child seen an eye doctor (an ophthalmologist, M.D. or an optometrist, O.D.) ? YES ☐ NO ☐

If yes, put DOCTOR'S NAME here: _____

DOCTOR'S ADDRESS or PHONE : _____

ADDITIONAL VISION INFORMATION (diagnosis, glasses or other treatment, follow up scheduled or anticipated) :

_____

RISK FACTORS FOR VISION LOSS

These are family and medical history details that have a high incidence of vision loss in infants and toddlers

***Note:** If your child has identified RISK FACTORS, ask your health care provider to share information with you about how identified risk factors pertain to your child's history & health.*

- ☐ **Family history of eye conditions other than glasses wear or age related cataracts?**

LIST Family eye condition: _____

- ☐ **Meningitis or encephalitis**
- ☐ **Maternal history of infection during pregnancy** (CMV, toxoplasmosis, rubella, STD)
- ☐ **Premature birth of 36 weeks or less** ***NUMBER OF WEEKS:***
- ☐ **Exposure to oxygen more than 24 hours**
- ☐ **Head trauma episode**
- ☐ **Seizure Disorder**
- ☐ **Birth Weight of less than 3 lbs. (or 1300 grams)** ***BIRTH WEIGHT:***
- ☐ **Neurological Issues**
- ☐ **Significant prenatal exposure to alcohol or drugs including prescription drugs**
- ☐ **A parent/caregiver concern about the way the child uses vision.**

LIST CONCERNS:

_____

_____

BEHAVIORAL SIGNS THAT MIGHT INDICATE VISION LOSS

These are known ways that young children behave when they are experiencing some difficulty using their vision

***Note:** If your child has identified BEHAVIORIAL SIGNS, send a copy of the completed checklist to your child's health care provider for review. Ask your provider to discuss referring your child to a pediatric eye doctor with you.*

- ☐ **Tilts or turns head to one side while looking** (child is older than 6 months)
- ☐ **Does not notice people or objects when placed in certain areas**
- ☐ **Responds to toys only when there is an accompanying sound** (child is older than 6 months)
- ☐ **Moves hand or object back and forth in front of eyes** (child is older than 12 months)
- ☐ **Eyes make constant, quick movements or appear to have a shaking movement (nystagmus)**
- ☐ **Squints, frowns or scowls when looking at objects**
- ☐ **Consistently over or under reaches** (child is older than 6 months)
- ☐ **Cannot see a dropped toy** (child is older than 6 months)
- ☐ **Brings objects to one eye rather than using both eyes to view**
- ☐ **Covers or closes one eye frequently**
- ☐ **Eyes appear to turn inward, outward, upward, or downward** (child is older than 6 months)
- ☐ **Places an object within a few inches of eyes to look** (child is older than 12 months)
- ☐ **Trips on curbs or steps** (child is older than 18 months)
- ☐ **Thrusts head forward or backward when looking at objects**
- ☐ **Eye-poking, rocking, staring at bright lights frequently**

☐ **No indicators are checked. Further attention to vision is not indicated at this time.**

☐ **One or more risk factors have been identified. Copy to family for risk factor discussion with family health care provider.**

☐ **One or more behavioral signs have been identified. Copy to family for their health care provider to review for health care system referral to a pediatric eye doctor for a complete eye exam.**

A checklist screening is a general indicator. Not every child with a screening checkmark will have a vision problem.
Some children without a checkmark will still have a vision problem that was not consistent enough to show up when the checklist was completed. If your child begins to show signs of poor vision use or if there is a significant change in vision, contact your child's health care provider.

REQUIRED Signature below of early childhood staff person completing this form with parent/caregiver: