Vision Survey for Families
The following survey assists in determining if your student requires additional vision evaluations. If concerns are noted, your student may have a vision screening completed, and/or a vision referral will be sent home.
Regarding your student, please answer the following questions

<table>
<thead>
<tr>
<th>Has your student been evaluated for vision screening by a health care provider?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your student currently wear glasses or contacts?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Eye Appearance**

- Eyes turn out/eyes are crossed
- Eyelid(s) are droopy
- Eyes are hazy or clouded
- Different sized pupils

<table>
<thead>
<tr>
<th>Eyes are:</th>
<th>Red</th>
<th>Crusty</th>
<th>Swollen lids</th>
<th>(circle those that apply)</th>
</tr>
</thead>
</table>

**Behavior Observations**

- Holds book close to face
- Sits up close when using the computer
- Uses finger as a guide on book when reading
- Blinks excessively while reading
- Feels things to assist with interpretation
- Makes errors when copying words from paper to paper/computer

**Complaints**

- Eyes hurt or blur after reading for a short period of time
- Unable to see objects at a distance

<table>
<thead>
<tr>
<th>Headaches</th>
<th>Dizziness</th>
<th>Nausea</th>
<th>(circle those that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Itching</td>
<td>Burning</td>
<td>Scratching</td>
<td>(circle those that apply)</td>
</tr>
</tbody>
</table>

**Additional Concerns:**

Student Name______________________________________________ Grade________________

Parent Signature____________________________________________ Date__________________