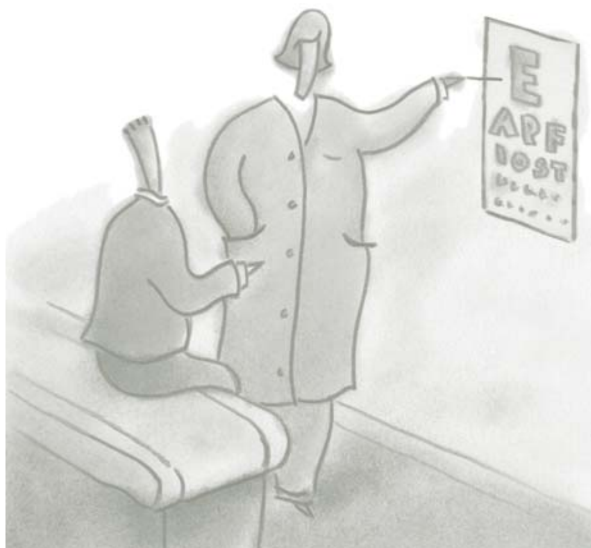
# VISION CARE CHECKLIST

## *for California Kids*



As a child grows, it is very important to make sure that his or her vision develops normally. Regular eye exams (starting as early as 6 months) can help parents, teachers and school nurses be certain that a child does not have any signs of vision-related medical problems, such as tumors or eye diseases that could lead to blindness, or vision problems that could harm his or her ability to read and learn. Since vision changes can occur quickly and without detection, it is important that a child visit an optometrist at least every two years for a comprehensive eye exam, or more frequently if specific problems or risk factors exist.

In between comprehensive exams, the simple checklist below can help you determine if the child's vision is developing normally. For best results, use these questions as a supplement to the 20/20 Snellen Wall Chart to identify near binocular vision problems that adversely affect reading and learning. If the answer is "yes" to two or more questions, the child may need an appointment with an optometrist for additional testing. The more "yes" answers, the greater the chance of learning-related problems that may need treatment.

**Do any of the following statements describe the child being tested?**

❑ Yes ❑ No Behind a grade level or more in school.
❑ Yes ❑ No Consistently performs below potential.
❑ Yes ❑ No Complains of blurred vision during reading and writing.
❑ Yes ❑ No Uses finger as a marker when reading.
❑ Yes ❑ No Makes frequent reversals when reading and writing.
❑ Yes ❑ No Skips and rereads words and/or letters.
❑ Yes ❑ No Omits or confuses small words when reading.
❑ Yes ❑ No Frowns, or squints to see.
❑ Yes ❑ No Turns or tilts head to use one eye only.
❑ Yes ❑ No Avoids close work or detailed activities.
❑ Yes ❑ No Reads in dim light.
❑ Yes ❑ No Loses place while reading.
❑ Yes ❑ No Holds reading material closer than normal.
❑ Yes ❑ No Holds reading material farther than normal.
❑ Yes ❑ No Bothered by glare from a page.
❑ Yes ❑ No Sensitive to bright light.
❑ Yes ❑ No Reports sensation of eyes "not working together".
❑ Yes ❑ No One eye turns inward, outward, upward or downward at any time.
❑ Yes ❑ No Tires of near work in a short time.
❑ Yes ❑ No Reports pain around or in the eye at any time.
❑ Yes ❑ No Red, irritated eyes or lids.
❑ Yes ❑ No Excessive tearing of eyes.
❑ Yes ❑ No Rubs eyes frequently.
❑ Yes ❑ No Closes or covers one eye in bright light or during visual tasks.
❑ Yes ❑ No After reading or close work, distance vision is blurry.
❑ Yes ❑ No Print swims, moves, floats, and doubles.
❑ Yes ❑ No Sees double (two of a single thing).
❑ Yes ❑ No Gets headache with eye use.
❑ Yes ❑ No Experiences difficulty with eye-hand-body coordination.
❑ Yes ❑ No Tends to bump into objects.

*If the answer was "yes" to two or more of the statements above, please complete the following information and schedule an appointment for the child to see an optometrist for further testing.*

Date ____________________

Child's Name ____________________________________________ Age ____________

Grade ____________ School ______________________________ City ________________

This checklist was completed by (circle one or more)

Parent Teacher School Nurse Student Other ______________________________

Phone (optional) ______________________

Additional Comments ____________________________________________

____________________________________________________________

This checklist has been provided to you by the California Optometric Association.