Student Wellness Services
9361 S 300 E
Sandy, UT 84070

Vision Symptoms Questionnaire

Adapted from Utah Department of Health in accordance with UCA 53G-9-404

Student Name		Referral Date	
School		Grade		Teacher	
Name and Title of Person Completing the Form	
Does the student wear glasses?	☐ yes ☐ no

Teachers are required to complete this form if a student is being referred for special education services related to a specific learning disability, emotional disturbance, or multiple disabilities. Parents/teachers may also complete this form if there is a vision concern.

If answer is 'yes' to any areas below, please provide additional information in the comment section(s).

	Yes	No	Additional Comments
As a teacher or parent are you concerned with this student's vision?			
Appearance Symptoms			
Tilts head, squints, closes or covers one eye when reading			
Gaze issues, eyes turn in or out, crossed eyes, eyes wander			
Different size pupils or eyes			
Watery eyes, eyes appear hazy or clouded			
Eye rubbing while reading or writing			
Complaints (Student Statements) Symptoms *(please specify student complaints in comments section)*			
Words float, move, or jump around when reading			
Complains of headaches, dizziness, or nausea when reading			
Complains of itching, burning, or scratchy eyes			
Complains of blurred or double vision, unusual sensitivity to light, or difficulty seeing			
Behavior Symptoms			
Loses place when reading			
Skips over or leaves out small words when reading			
Writes uphill or downhill; difficulty writing in a straight line			
Has difficulty copying from the board			
Avoids near work, such as reading and writing			
Has difficulty lining up numbers when doing math			
Has difficulty finishing assignments on time			
Holds books too close; leans too close to a computer screen			
Clumsy; bumps into things; knocks things over			
Poor spacing of words while handwriting			
Poor letter size and height while handwriting			

When complete, please give this form to the school nurse for tier 2 evaluation and possible referral to an eye care professional.

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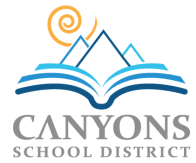

Student Name					
FOR SCHOOL NURSE USE ONLY ● Any parent or teacher concern and/or any 'yes' answers should be evaluated by the school nurse to determine if tier 2 screening or referral to an eye care professional is necessary. ● School nurse should use their professional nursing judgment in determining whether the student receives a tier 2 vision screening and/or is referred to an eye care professional, regardless of the answers.					
Distance Vision Screened	☐ pass	☐ fail			
Near Vision Screened	☐ pass	☐ fail			
Saccades & Pursuits Screened	☐ Yes	☐ No	If yes: ☐ pass	☐ fail	
Convergence Screened	☐ Yes	☐ No	If yes: ☐ pass	☐ fail	
Color Vision Screened	☐ Yes	☐ No	If yes: ☐ pass	☐ fail	
Hearing Screened	☐ Yes	☐ No	If yes: ☐ pass	☐ fail*	
**Note: if the student does not pass initial hearing screening, they should be re-screened in 3-4 weeks*					
Referred to eye care professional	☐ Yes	☐No	Date		
Referred to healthcare provider	☐ Yes	☐No	Date		
Additional Notes					
School Nurse Name:					
School Nurse Signature:			Date		