

Note: ECI Policy says that if an eye report is already available at intake, the screening procedures (including the questionnaire) are not necessary; referral to the VI teacher at the local school district is made as soon as a visual impairment has been identified on the eye report. It is only when there is no eye report among the medical records that the vision screening questionnaire and testing are used.

## Parent Questionnaire

### Family History:

Does anyone in your family have a severe vision loss or eye disease?  Yes  
 No (e.g., albinism, amblyopia, cataracts, glaucoma, strabismus, retinoblastoma)

Yes  No If so, what \_\_\_\_\_

Did the child's mother have any serious infections or diseases during pregnancy?  
 Yes  No (e.g., rubella, cytomegalovirus, toxoplasmosis, syphilis, herpes)

Yes  No If so, what: \_\_\_\_\_

Did the child's mother use drugs or alcohol during pregnancy?

Yes  No If so, which: \_\_\_\_\_

Was the child's mother exposed to any environmental hazards during pregnancy?  
 Yes  No (e.g., chemicals, radiation)  Yes  No. If so, what:

### Birth History:

Was the child born prematurely?  Yes  No

If so, how early was he/she? \_\_\_\_\_

What was the child's birth weight: \_\_\_\_\_ (3 pounds or under is cause for concern.)

Were there any post-natal infections?  Yes  No (e.g., Meningitis, encephalitis hydrocephalus, prolonged fever, convulsions)

Yes  No If so, what:

Was there any kind of head trauma at birth (or shortly thereafter)?

Yes  No If so, describe: \_\_\_\_\_

### Other Relevant History:

Has any syndrome been identified?  Yes  No

If so, what: \_\_\_\_\_

Has cerebral palsy been identified? \_\_\_ Yes \_\_\_ No

Has any neurological disorder been identified? \_\_\_ Yes \_\_\_ No (especially the occurrence of seizure activity) \_\_\_ Yes \_\_\_ No

Does your child take any medications? \_\_\_ Yes \_\_\_ No (e.g., anti-convulsive medication) \_\_\_ Yes \_\_\_ No

If so, what: \_\_\_\_\_

Has a hearing problem been identified or suspected? \_\_\_ Yes \_\_\_ No

Do you have any concerns about your child's vision? \_\_\_ Yes \_\_\_ No

If so, what: \_\_\_\_\_

## Functional Skills:

Functional skill is followed by "Age of normal achievement" in parenthesis.

### Looking:

Does your child look at your (or the caregiver's) face, even momentarily? \_\_\_ Yes \_\_\_ No (1 Mo.)

Does your child look at his/her own hands? \_\_\_ Yes \_\_\_ No (3-4 mos.)

Does your child look at toys? \_\_\_ Yes \_\_\_ No (3-4 mos.)

Does your child notice small objects e.g., raisin, Cheerios, lint)? \_\_\_ Yes \_\_\_ No (4 mos.)

Does your child watch people at least 6 feet away? \_\_\_ Yes \_\_\_ No (6 mos.)

Does your child look for toys that have been dropped? \_\_\_ Yes \_\_\_ No (9 mos.)

Is your child interested in pictures or picture books? \_\_\_ Yes \_\_\_ No (12 mos.)

### Reaching:

Does your child bat at objects that are suspended above him/her? \_\_\_ Yes \_\_\_ No (3 mos.)

Does your child try to reach out and grasp toys or objects? \_\_\_ Yes \_\_\_ No (6 mos.)

Does your child try to pick up a small object? \_\_\_ Yes \_\_\_ No (e.g., raisin, Cheerio, lint) (8 mos.)

Does your child try to grab at your glasses or jewelry?  Yes  No (9 mos.)

Does your child reach into a container and try to pull out an object?  Yes  No (12-18 mos.)

**Locomotion:**

Does your child notice an interesting object at least 5' away and indicate an interest/desire to have it?  Yes  No (by pointing, having arms, babbling, making hand movements) (6-7 mos.)

Does your child move, by any means, towards an interesting object at least 5' away?  Yes  No (7-8 mos.)

**Social:**

Does your child react differently to different faces or people?  Yes  No (6 mos.)

Does your child react to facial expressions (e.g. , smile, frown, "funny face")?  Yes  No (10- 12 mos.)



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Please complete the comment form or send comments and suggestions to: Jim Allan (Webmaster-Jim Allan)

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