NSSEO
Building a Promising Future for Students

Diagnostic & Educational Services Center (DESC)
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## TEACHER CHECKLIST FOR POSSIBLE VISION PROBLEMS - SCHOOL AGE CHILDREN

Student Name _____ Date _____

Attendance School _____ Res. District_____

Vision Teacher _____ Completed By_____

Date of Latest Eye Exam _____

Eye Doctor Information _____
(Name)

_____
(Address) (Phone)

Student wears prescription glasses? ☐ Yes ☐ No

Please check any of the items below that pertain to the student.

- ☐ Eye turns in or out (☐ Right ☐ Left ☐ Both)
- ☐ Reddened eyes or lids
- ☐ Eyes tear excessively
- ☐ Head turns as reads across page
- ☐ Loses place often during reading
- ☐ Displays short attention span in reading or copying material
- ☐ Too frequently omits words during reading
- ☐ Writes up or down hill on paper
- ☐ Has difficulty staying on lined paper
- ☐ Orients drawing and columns poorly on page
- ☐ Complains of seeing double
- ☐ Squints, closes or covers one eye
- ☐ Moves in unusually close to read printed material
- ☐ Blinks excessively at desk task and/or reading
- ☐ Avoids all possible near-centered tasks
- ☐ Makes errors in copying material from distance to near
- ☐ Makes errors in copying from books to paper
- ☐ Rubs eyes during or after short periods of visual activity
- ☐ Complains about too little light
- ☐ Complains about too much light
- ☐ Bumps into objects (☐ to the right ☐ to the left ☐ in lower)
- ☐ Jerky eye movements

Specific concerns or questions

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