Early Childhood Vision Observation and Interview Protocol

(Ages birth to three) To be completed by ECSE Teacher or related service provider.

Date: _____ Completed By: _____

Child's Name: _____ Age: Years_____Months_____

Eye conditions which should initiate contact with a Teacher of the Blind/Visually Impaired (TBVI):

Albinism	CHARGE Syndrome	Coloboma
Congenital Cataracts	Cortical Visual Impairment (CVI)	Delayed Visual Maturation
Lebers Amaurosis	Nystagmus	Optic Nerve Hypoplasia
Retinoblastoma	Retinopathy of Prematurity	Septo-optic Dysplasia
Sticklers Syndrome	Ushers Syndrome	

Does the child have glasses or contacts? (Circle yes or no)	Yes No
Wearing glasses or contacts when observed? (Circle yes or no)	Yes No

Circle any concern that is observed below. If one or more item/s is circled, contact and copy form to: School Nurse if available and assigned TBVI.

A. External Inspections:

1. Eyes do not appear straight (one or both eyes turn inward or outward).
2. Extreme redness
3. Pupils are not equal and round
4. Significant drooping of the eyelids or lashes turning inward
5. Roving/involuntary/abnormal eye movement
6. Uncertain, difficult to describe

B. Binocular Fix & Follow:

1. Eyes do not stay together when viewing a stationary object
2. Eyes do not move together when following a target, horizontal and vertical

C. Natural Visual Response

Child **does not**:

1. look attentively at face
2. visually follow a person
3. reach for objects
4. look at named objects
5. display a blink reflex

Vision History: To be completed by parent or guardian

Are you concerned about your child's vision? Yes No

Has your child ever had their vision tested? Yes _____(date) No

Has your child been diagnosed with a vision condition? Yes _____(condition) No

Does your child use his/her eyes to visually explore objects? Yes No

Does your child visually follow people or objects as they move past him/her? Yes No

Does your child see small things? (i.e. Cheerio on a tray) Yes No

Does your child see things at a distance? (i.e. you approach from across the room) Yes No

Do both of your child's eyes look the same in pictures? Yes No

Do your child's eyes have an unusual appearance? Yes (Give description below) No

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Does your child show sensitivity to light (extreme squinting or tearing)? Yes No

If your child is over 3 months of age, does he/she stare at lights for a long time? Yes No

Have you noticed any of the following:

- poor eye contact while being fed? Yes No
- poor eye contact toward other people? Yes No
- one eye wandering or moving differently than the other (when not sleepy)? Yes No
- poking at his/her eyes or frequently rubbing? Yes No
- excessive blinking? Yes No
- watery eyes? Yes No
- placing head too close to objects? Yes No
- covering or closing an eye when looking at objects? Yes No
- over or under reaching for objects? Yes No

Have any family members had eye problems that required treatment before entering school? Yes No

Has your child been diagnosed with any other medical conditions? Yes _____ No

Observation and Interview Protocol Results:

__ No concerns noted by ECSE Staff, Related Service Provider or Parent.

__ Concerns noted above: _____

Action: __ Referral School Nurse (Name: _____) on _____

__ Referral to TBVI (Name: _____) on _____

- For more information on vision screening, see the MDH Vision Screening Website.