St. Joseph School
York, PA • sjy.org

VISION QUESTIONNAIRE

Your child will receive a vision screening by the school nurse every year in school. You will be notified if your child does not pass the vision screening. Please be aware that this is only a screening and there is always a possibility that eye problems may exist that can only be diagnosed by an eye care specialist, such as an ophthalmologist or optometrist.

Name of Child: _____ Date:_____

Please answer the questions below and return this form to the School Nurse.

Does your child ever complain:

1. that he/she cannot see well?	YES	NO
2. that objects "run together"?	YES	NO
3. of headaches, dizziness, or nausea following close work?	YES	NO
4. of double vision?	YES	NO

Has your child ever had:

1. eyelids that are red-rimmed, encrusted, or swollen?	YES	NO
2. recurring styes or lid inflammation?	YES	NO
3. inflamed or watery eyes?	YES	NO
4. crossed eyes?	YES	NO
5. a photograph of his/her face in which you have noticed a cloudy whiteness of one eye?	YES	NO

Does your child ever:

1. have difficulty with tasks requiring close vision?	YES	NO
2. frown, blink excessively, or squint?	YES	NO
3. hold objects or books too close or too far away?	YES	NO
4. rub his/her eyes frequently?	YES	NO
5. shut or cover one eye, tilt or thrust head forward when looking at near or distant objects?	YES	NO
6. stumble or trip over small objects?	YES	NO
7. do poorly in activities requiring distant vision?	YES	NO

Has your child ever been examined by an eye specialist? YES NO
If so, by whom? _____

Does your child wear glasses or contact lenses? YES NO