Vision and Learning Checklist (Ages 6-12)

Name _____ Age_____ Grade_____

School _____ Date _____

Person Filling Out Form _____

Please put an "X" in the column that best shows how often this happens

How often does this happen? Points per X	Never 0	A little 1	Sometimes 2	A lot 3	Always 4
1. Headaches with reading or writing					
2. Words slide together or get blurry when reading					
3. Reads below grade level					
4. Loses place while reading					
5. Head tilt or closes an eye when reading					
6. Hard to copy from the board					
7. Doesn't like reading or writing					
8. Leaves out small words when reading					
9. Hard to write in a straight line					
10. Burning, itching, or watery eyes					
11. Hard to understand what has been read					
12. Holds book very close					
13. Hard to pay attention when reading					
14. Hard to finish assignments on time					
15. Gives up easily (says "I can't" before trying)					
16. Bumps into things, knocks things over					
17. Homework takes too long					
18. Daydreams					
19. In trouble for being off task at school					
20. Writes letters or numbers backwards					
Number of total marks in each column	____	____	____	____	____
Multiply total marks in each column by:	x 0	x 1	x 2	x 3	x 4
Score for each column:	____	____	____	____	____

Add scores for all columns together. Total score* _____

*Total score greater than 20 indicates the child is at risk for a vision-based learning problem. Further visual developmental testing is recommended. Research conducted by Northeastern State University College of Optometry showed that children who scored 20 or greater on the symptoms checklist had an 80% chance of having vision problems that make it difficult to read, learn, and/or pay attention in class. Vision symptoms can be similar to study technique symptoms and need to be evaluated by a professional.

(over)

Vision and Learning

Please answer the following questions:

1. Is your student in a regular classroom? Yes _____ No _____

2. Is your student in a self contained Special Education program? Yes _____ No _____

3. Does your student go to a Resource Room for help? Yes_____ No _____

4. Does your student have a tutor? Yes _____ No _____

5. Has your student had Educational Testing? Yes _____ No _____

6. Has your student been diagnosed with a learning disability? Yes _____ No _____

7. Does your student receive:
   Speech Therapy? Yes _____ No _____
   Occupational Therapy? Yes _____ No _____
   Physical Therapy? Yes _____ No_____

8. Has your student repeated a year in school? Yes _____ No _____
   If so, which grade? _____

9. Does your child have an Individualized Education Plan (IEP)? Yes _____ No _____
   If yes, which services are received? _____

10. Has your child ever been diagnosed or been suspected of having ADD/ADHD?
    Yes _____ No_____
    If yes, is your child using medication? Yes _____ No _____
    If yes, please list: _____