

Salt Lake City School District

Handicapped Vision Screening Form

Student _____ DOB/AGE _____ Male/Female

School _____ Grade/Program _____ Rm _____ Date _____

1) Distance Visual Acuity Both 20/ _____ Right Eye 20/ _____ Left 20/ _____
Unable to Test

2) Color Blind Yes/No Unable to Test

3) Near Visual Acuity Both _____ Right _____ Left _____
Unable to Test

4) Medications Currently taking? _____

Not Applicable Unknown/Unavailable

5) List pertinent information from previous eye exams or other health records _____

Not Applicable Unknown/Unavailable

6) OBSERVATIONS: Circle Those Observed

Esotropic Strabismus

Exotropic Strabismus

Nystagmus (Jerky Movements)

Conjunctivitis

Blepharitis (Eye Lids)

Ptosis (Drooping Eye Lid)

Facial Response (Eye to Eye Contact)

Large eyes (> 9-10 mm)

7) MARK “Good”, “Fair”, or “Bad”

_____ **Head Positioning**

_____ **Tracking (Peripheral Vision)**

_____ **Tracking (Across Mid-Line)**

_____ **Convergence (Focusing)**

_____ **Pupillary Response**

8) Circle If Student Complains of Any of the Following:

Headaches

Itchy Eyes

Burning eyes

Blurry Vision

Double Vision

Dizziness

9) Circle If You Observed Any Of The Following?

Frowning or Scowling

Unresponsiveness

Lack of Visual Curiosity

Squinting

Excessive Blinking

Rubbing Eyes

Closed or Covered One Eye

Preferential Use of One Eye

Excessive Tearing

Inadequate Tearing

Stye(s)

“Milky” eyes

White Spot on Eye(s)

Holds Objects/Books/Toys Close To Eyes

Bumps Into Things

Sits Close to TV/Board/Teacher, etc.

Abnormal Gait

Trips Over Objects on Floor

Uses hands, Face, and/or Tongue to Assist in Interpretation of objects

Avoids Close or Distant Work Activities

10) Additional Findings:

Referred For Professional Eye Care? Yes _____ No _____

Signature and Title of Vision Screener:
