

VISION CHECKLIST FOR YOUNG CHILDREN

NAME: _____ **AGE:** _____ **DATE:** _____

1. APPEARANCE OF THE EYES

- _____ ONE EYE TURNS IN OR OUT AT ANY TIME
- _____ REDDENED EYES OR EYELIDS
- _____ EYES TEAR EXCESSIVELY
- _____ BLINKS EXCESSIVELY
- _____ RUBS EYES FREQUENTLY DURING OR AFTER SHORT PERIODS OF VISUAL ACTIVITY

2. BEHAVIORAL SIGNS OF VISUAL PROBLEMS

- _____ SQUINTS, CLOSES OR COVERS ONE EYE
- _____ TILTS HEAD EXTREMELY WHILE WORKING OR PLAYING AT NEAR
- _____ FEELS RATHER THAN LOOKS AT THINGS
- _____ AVOIDS LOOKING AT BOOKS AND PUZZLES, PREFERS TOYS HE CAN HANDLE
- _____ HOLDS BOOKS TOO CLOSELY; FACE CLOSE TO DESK SURFACE
- _____ SITS VERY CLOSE TO TV (WHEN REPEATEDLY MOVED BACK)
- _____ COLOURING - CANNOT STAY WITHIN THE LINES (FOR AGE GROUP) OR IGNORES THE LINES

3. OTHER SIGNS / PROBLEMS NOTED

COMPLETED BY: _____
PARENT / TEACHER / OTHER