Appendix 2.3.3

Kindergarten Vision Checklist

(To be completed by Parent)

To the Teacher: *Most children will exhibit some of these symptoms occasionally. If a child exhibits more than one of these symptoms routinely, parents should be contacted to arrange for an eye examination for their child.*

Student:______________________________ D.O.B.:______________________

School:______________________ JK:☐ SK:☐ Entry Date____________________

Name of Person Completing This Form_________________________

Relationship to Student: ____________________ Date Completed:________________

✓Appearance of Eyes:

___ One eye turns in or out at any time

___ Reddened eyes or lids

___ Encrusted eyelids

___ Frequent styes on eyelids

___ Eyes tear excessively

✓Complaints When Looking at Print or Pictures

___ Headaches

___ Burning or itching eyes

___ Nausea or dizziness

___ Avoids near vision tasks if possible

___ Print blurs or moves

___ Double vision

___ Difficulty seeing clearly after close work

___ Keeps face to close to books or table work

___ Closes or covers one eye when doing a visual task

___ Squints to see things at a distance or requests to move closer

___ Rubs eyes during or after periods of visual activity

___ Extremely tilted head while looking at things near or far away

___ Blinks excessively while looking at things near or far away

___ Blinks when changing from near to far away tasks

Do you have any concerns about colour vision? Yes ___ No ___

Do you have any other concerns not mentioned above? Yes ___ No ___ If yes, please explain:

____

____

____

Parents, please return completed form to school:

Parent/Guardian Signature:___________________________ Date:______________