

Strasburg Vision and Learning Center
717-687-8141
Teacher Questionnaire

To the teacher of _____ Grade _____ School _____

The child named above is receiving vision care in our office. In order to address the impact of vision problems on classroom performance, we would like your observations of this child's behavior in school. It has been shown that the teacher is frequently the best observer for identifying vision problems that tend to interfere with schoolwork. The following checklist identifies many of the observable clues and symptoms that are often observed in a child with a vision problem. Please read through this list and check items that you have noted to occur *frequently* in this child's case.

Appearance of Eyes

- Reddened eyes or lids
- Excessive tearing or rubbing of eyes
- Blinks excessively

Refractive Error/Eye Focusing Problems

- Blinks excessively during near tasks
- Frowns, scowls, or squints to see board
- Avoids close work
- Fatigues easily during visual tasks
- Rubs eyes during or after visual tasks
- Complains of blur while reading or performing near tasks
- Comprehension is poor when reading or performing near tasks

Eye Tracking Problems

- Skips or rereads words or letters
- Rereads lines or phrases
- Mistakes words with similar beginnings
- Uses fingers as marker when reading
- Loses place often when reading
- Repeatedly omits "small" words
- Moves head excessively as reads across a page

Eye Teaming Problems

- Complains of seeing double
- Covers or closes one eye
- One eye turns (in, out or down)
- Tilts or turns head to one side
- Squints, closes or covers one eye
- Complains of letter or lines floating or jumping

Visual Information Processing

- Confuses similar words
- Fails to recognize same word in next sentence or page
- Confuses minor likenesses and difference.
- makes errors in copying from board or text book.
- Difficulty following instruction
- Difficulty completing assignments in time allotted
- Poor printing or handwriting
- Short attention span, distracted
- Says words aloud or moves lips as reading.
- Reverses letters, numbers or words
- Poor ability to remember what is read.
- Poor eye-hand coordination
- Repeatedly confuses right-left
- Poor recall of visual tasks

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Please comment on the following:

Does this child have any academic problems? Yes _____ No _____

Is so, please explain (e.g. subject, material, behavior, etc.) _____

Is (s)he in the top third, middle third or lower third of his/her class? _____

How does academic achievement compare with potential? _____

Is this child reading below, above or on grade level? _____

PLEASE CHECK ANY AREA OF DIFFICULTY:

- | | | |
|--|---|---|
| <input type="checkbox"/> Vocabulary | <input type="checkbox"/> Word Recognition | <input type="checkbox"/> Penmanship |
| <input type="checkbox"/> Reading fluency | <input type="checkbox"/> Fine Motor Skills | <input type="checkbox"/> Silent Reading |
| <input type="checkbox"/> Ability to stay on task | <input type="checkbox"/> Gross Motor Skills | <input type="checkbox"/> Memory |
| <input type="checkbox"/> Math Skills | <input type="checkbox"/> Comprehension | <input type="checkbox"/> Written Work |
| <input type="checkbox"/> Spelling | | |

Do you feel there are any factors that may be interfering with academic achievement? Please explain:

Any other observations and/or comments that you feel may be helpful to us would be appreciated: _____

May we contact you if further information is required? Yes _____ No _____

If yes, please complete:

Teacher _____ Phone: _____

Best time to call : _____ Email Address: _____

School Name: _____ Address: _____

Signature _____ Date: _____

I hereby give my consent to release the above information

Parent or Guardian Signature

Date