ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Arizona Early Intervention Program (AzEIP)

VISION SCREENING CHECKLIST

○ Initial IFSP ○ Annual IFSP

Note to Screeners and Parents:

This screening was developed to use with infants, toddlers and young children who cannot participate in an acuity screening.

When a child can match, select, identify or name a picture or symbol that is the same as the one the screener is showing to the child, one of the formal acuity screenings designed for early learners should be given as a supplement to this checklist screening.

Child's Name: _____

Screener Agency: _____

Child's Date of Birth: _____ Chronological Age *(At time of screening)*: _____

Adjusted Age *(For prematurely children now under two years, subtract number of weeks prematurely from the chronological age)*: _____

PERSON(S) COMPLETING THE CHECKLIST

(Write your role on the child's team or your agency after your name)

Parent/Cargiver: _____

Other: _____ Other: _____

Screener Note:

Completed screenings with indicators checked require **a family copy** to share with health care provider. If your child has not seen an eye doctor yet, completing this screening will give you an indication of possible concerns or signs to watch for. If your child has already seen an eye doctor, completing this screening will tell more about how your child uses vision. **THERE IS NO SCREENING THAT WILL SUBSTITUTE FOR AN EYE EXAM BY A PEDIATRIC EYE DOCTOR.**

Has the child seen an eye doctor *(an ophthalmologist, M.D. or an optometrist, O.D.)*? ☐ Yes ☐ No

Doctor's Name: _____

Address *(No., Street)*: _____

City: _____ State: _____ ZIP Code: _____ Phone Number: _____

Additional Vision Information *(Diagnosis, glasses or other treatment, follow up scheduled or anticipated)*:

_____

RISK FACTORS FOR VISION LOSS

These are family and medical history details that have a high incidence of vision loss in infants and toddlers.

☐ Family history of eye conditions other than glasses, wear or age-related cataracts

List family eye condition(s): _____

☐ Meningitis or encephalitis ☐ Maternal history of infection during pregnancy (CMV, toxoplasmosis, rubella, STD)

☐ Premature birth of 36 weeks or less Number of weeks: _____ ☐ Exposure to oxygen more than 24 hours

☐ Head trauma episode ☐ Seizure Disorder ☐ Neurological Issues

☐ Birth Weight of less than 3 lbs (or 1300 grams) Birth Weight: _____

☐ Significant prenatal exposure to alcohol or drugs including prescription drugs

☐ A parent/caregiver concern about the way the child uses vision

***Note:** If your child has identified **RISK FACTORS**, ask your health care provider how the risk factors might affect your child's vision.

See page 2 for EOE/ADA disclosures

BEHAVIORAL SIGNS THAT MIGHT INDICATE VISION LOSS

These are known ways that young children behave when they are experiencing some difficulty using their vision.

- ☐ Tilts or turns head to one side while looking (Older than 6 months)
- ☐ Does not notice people or objects when placed in certain areas
- ☐ Responds to toys only when there is an accompanying sound (Older than 6 months)
- ☐ Moves hand or object back and forth in front of eyes (Older than 12 months)
- ☐ Eyes make constant, quick movements or appear to have a shaking movement (This is called nystagmus)
- ☐ Squints, frowns or scowls when looking at objects
- ☐ Consistently over or under reaches (Older than 6 months)
- ☐ Cannot see a dropped toy (Older than 6 months)
- ☐ Brings objects to one eye rather than using both eyes to view
- ☐ Covers or closes one eye frequently
- ☐ Eyes appear to turn inward, outward, upward, or downward (Older than 6 months)
- ☐ Trips on curbs or steps (Older than 18 months)
- ☐ Places an object within a few inches of eyes to look (Older than 12 months)
- ☐ Thrusts head forward or backward when looking at objects
- ☐ Eyepoking, rocking, staring at bright lights frequently

***Note:** If your child has identified **BEHAVIORIAL SIGNS**, send a copy of the completed checklist to your child's health care provider and ask to discuss referring your child to a pediatric eye doctor.

☐ **No indicators** are checked. Further attention to vision is not indicated at this time.

☐ **One or more risk factors** have been identified. **Copy to family** for risk factor discussion with family health care provider.

☐ **One or more behavioral signs** have been identified. **Copy to family** for their health care provider to review for health care system referral to a pediatric eye doctor for a complete eye exam.

A checklist screening is a general indicator. Not every child with a screening checkmark will have a vision problem. Some children without a checkmark will still have a vision problem that was not consistent enough to show up when the checklist was completed. If your child begins to show signs of poor vision use or if there is a significant change in vision, contact your child's health care provider.

_____ _____

Person's Signature Completing this Form with Parent/Caregiver (Required) *Date*