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## Teacher Questionnaire

To the teacher of \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_

The child named above is receiving vision care at our clinic. 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 school work. 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 of eyes, or rubs eyes
- ☐ Blinks excessively
- ☐ Encrusted eyelids
- ☐ Frequent styes on eye
- ☐ One eye turns (in, out, up or down) at any time

### **Refractive Error or Eye Focusing (Accommodation) Problem**

- ☐ Blinks eyes excessively during near tasks
- ☐ Frowns, scowls, or squints to see blackboard
- ☐ Avoids close work
- ☐ Fatigues easily during visual tasks
- ☐ Rubs eyes during or after visual activity
- ☐ Complains of blur while reading or writing
- ☐ Burning or itchy eyes after reading/writing
- ☐ Comprehension is poor when reading or performing near tasks
- ☐ Nausea or dizziness
- ☐ Headache in forehead or temples
- ☐ Mispronounces similar words as continues reading
- ☐ Complains of discomfort in tasks that demand visual interpretation
- ☐ Avoids all possible near-centered tasks

### **Eye Tracking (Ocular Motility) Problem**

- ☐ Skips or rereads words or letters
- ☐ Rereads lines or phrases
- ☐ Mistakes words with similar beginnings or endings
- ☐ Uses finger or marker when reading
- ☐ Loses place often when reading
- ☐ Repeatedly omits "small" words

- ☐ Moves head excessively as reads across page
- ☐ Misaligns digits in number columns

### **Eye Teaming (Binocularity) Problem**

- ☐ Complains of seeing double
- ☐ Covers or closes one eye
- ☐ One eye turns (in, out, up, or down) at any time
- ☐ Tilts or turns head to one side
- ☐ Squints, closes, or covers one eye
- ☐ Complains of letters or lines "floating," "running together," or "jumping around"
- ☐ Reports confusion of what is seen
- ☐ Displays short attention span in reading or copying

### **Visual Information-Processing Problem**

- ☐ Confuses similar words
- ☐ Fails to recognize same word in next sentence or page
- ☐ Confuses minor likenesses and differences
- ☐ Makes errors in copying from chalkboard or reference book
- ☐ Difficulty following verbal instructions
- ☐ Difficulty completing assignments in time allotted
- ☐ Poor printing or handwriting
- ☐ Short attention span, distractible
- ☐ Says words aloud or moves lips as reads
- ☐ Reverses letters, numbers, or words
- ☐ Poor ability to remember what is read
- ☐ Poor eye-hand coordination
- ☐ Repeatedly confuses right-left directions
- ☐ Poor recall of visually-presented tasks
- ☐ School performance not up to potential

Please comment on the following:

1. Does this child have any academic problems? Yes\_\_\_\_\_ No\_\_\_\_\_

If so, please explain (e.g., subject material, behavior, etc.) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. Is (s)he in the top third, middle third, or lower third of his/her class? \_\_\_\_\_

3. How does academic achievement compare with potential? \_\_\_\_\_

\_\_\_\_\_

4. At what grade level does this child read? \_\_\_\_\_

5. Please check any areas of difficulty:

- |                                         |                                           |                                       |                                        |
|-----------------------------------------|-------------------------------------------|---------------------------------------|----------------------------------------|
| <input type="checkbox"/> Vocabulary     | <input type="checkbox"/> Word Recognition | <input type="checkbox"/> Oral Reading | <input type="checkbox"/> Reading Rate  |
| <input type="checkbox"/> Interpretation | <input type="checkbox"/> Silent Reading   | <input type="checkbox"/> Attention    | <input type="checkbox"/> Comprehension |
| <input type="checkbox"/> Memory         | <input type="checkbox"/> Math Skills      | <input type="checkbox"/> Spelling     | <input type="checkbox"/> Written Work  |

6. Do you feel that there are any factors that may be interfering with academic achievement?

\_\_\_\_\_

\_\_\_\_\_

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7. Any other observations and/or comments which you feel may be beneficial to us would be appreciated.

\_\_\_\_\_

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May we contact you if further information is required? If so, please provide a telephone number or email at which you can be reached and the best time to call.

Teacher \_\_\_\_\_ Best Time \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

School Name \_\_\_\_\_ City \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

I hereby give my consent to release the above information

\_\_\_\_\_ Date \_\_\_\_\_

Parent or Guardian Signature