

TAKING A LOOK!

*A First Step in Vision Assessment
for Ohio's Infants and Toddlers*
(Revised for Dissemination)

Vision Screening Checklist with Guidelines for Completion

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Vision screening is an effort to facilitate the early diagnosis and corrective medical treatment of many vision problems in young (and developmentally young) children. Early treatment of children's vision concerns is vital to life-long visual functioning. Vision screening additionally serves as a tool for identifying infants and toddlers who may have (uncorrectable) visual impairments. Early identification allows young children who are visually impaired, and their families, to benefit from vision-related intervention services that prevent or minimize developmental delays commonly associated with visual impairment and blindness.

"Taking A Look!" is a *first* step in assessing vision and obtaining needed medical eye care for infants and toddlers. It was created by a committee of Ohio educators serving young children who are blind or visually impaired, in response to federal (Part C) vision screening requirements and state of Ohio vision screening mandates for all children entering Ohio's "Help Me Grow" system. "Help Me Grow" provides services for infants and toddlers who exhibit a variety of developmental concerns, and their families.

The primary objectives of "Taking A Look!" are: 1) to pinpoint "red flag" indicators of potential vision problems; 2) to facilitate referrals to medical eye care professionals for comprehensive eye examinations; and 3) to guide parents and early childhood professionals in observing young children to identify possible vision problems. The overall goal of "Taking A Look!" is to promote a more comprehensive effort to identify Ohio's infants and toddlers with vision problems and to obtain medical care and vision-related educational services for them in a timely manner.

This booklet includes a copy of the "Taking A Look!" checklist (pages 2-3) and detailed instructions for completing items included in its seven sections: Background Information; Child and Family History; Eye Appearance; Vision Concern Behaviors; Interview Questions; Additional Vision Assessments; and Results and Recommendations. It is intended to be used as: 1) a training guide for professionals attending workshops for learning to use the "Taking A Look!" checklist and 2) as a reference guide for staff completing the checklist with young children and their families. The screening process involves observing and gathering information about a child's vision by (and from) a variety of *trained* professionals (e.g., school nurses, teachers of children who are visually impaired, early intervention specialists, service coordinators, optometrists, and/or ophthalmologists), as well as family members of young children. The sections may be completed in any order.

TAKING A LOOK! CHECKLIST

Taking A Look - 2

A FIRST STEP IN VISION ASSESSMENT FOR OHIO'S INFANTS AND TODDLERS

Date: _____ County: _____

I. BACKGROUND INFORMATION

Child's Name: _____ DOB: _____
 Eye Doctor: _____ Seen in last year? _____ Next visit: _____
 Diagnosed vision problem? Y N If so, what? _____
 Eye treatment(s) __ glasses __ meds __ surgery __ patching __ other: _____ __ none
 Other diagnosed medical condition(s): _____
 Current medications: _____

Note: It is unnecessary to screen a child with a diagnosed visual impairment or a child followed by an eye doctor who has been seen within the last 12 months, as documented by a vision exam report.

_____ **CHECK HERE IF CHILD HAS A DIAGNOSED VISUAL IMPAIRMENT.**
 _____ Check here if child's medical vision exam report is attached to this form and no screening was conducted. Skip down to "Results and Recommendations" section.

II. CHILD AND FAMILY HISTORY

CHILD history includes:

- | | |
|---|--|
| <input type="checkbox"/> Birthweight less than 3 lbs. | <input type="checkbox"/> Hydrocephaly / Shunt |
| <input type="checkbox"/> Cerebral palsy / High or low muscle tone | <input type="checkbox"/> Meningitis / Encephalitis |
| <input type="checkbox"/> Child infection at birth | <input type="checkbox"/> Neurological disorder / Seizures |
| <input type="checkbox"/> Head trauma | <input type="checkbox"/> Prolonged high fever |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Syndrome w/risk of serious vision concern |
- _____ FAMILY history includes a member (child's biological parent, grandparent, aunt/uncle and/or sibling) with a significant vision concern or a visual impairment **not due to accident, injury or ageing** (generally identified prior to adulthood).

CHILD AND FAMILY HISTORY RISK FACTORS ARE NOTED IN SECTION II: YES NO

III. EYE APPEARANCE (With glasses? Y N N/A)

(Check off & indicate "O" for observed by screener or "P" for parent/guardian report)

Frequent or persistent presence of:

- | | |
|---|--|
| <input type="checkbox"/> Blank/"far away" look to eyes | <input type="checkbox"/> Red, swollen or encrusted eyelids |
| <input type="checkbox"/> Cloudy or "milky" appearance of eyes | <input type="checkbox"/> Squinting/closing/excessive blinking of eyes |
| <input type="checkbox"/> Droopy eyelid(s) | <input type="checkbox"/> Turning in/out/up/down of one or both eyes (2m) |
| <input type="checkbox"/> Jerky, "wiggling" eyes | <input type="checkbox"/> Unequal/unusual size/shape of eyes/pupils |
| <input type="checkbox"/> Random/"roving" eye movements (2m) | <input type="checkbox"/> Watery, red or irritated eyes |

EYE APPEARANCE CONCERNS ARE NOTED IN SECTION III: YES NO

IV. VISION CONCERN BEHAVIORS (With glasses? Y N N/A)

(Check off & indicate "O" for observed by screener or "P" for parent/guardian report)

Child consistently:

- | | |
|--|--|
| <input type="checkbox"/> Covers/closes one eye when looking | <input type="checkbox"/> Seems unaware of distant objects(6m) |
| <input type="checkbox"/> Fails to look at/point to pictures in a book (1/2y) | <input type="checkbox"/> Seems unaware of self in mirror (6m) |
| <input type="checkbox"/> Fails to notice objects above/below head (3m) | <input type="checkbox"/> Squints/closes eyes/cries/turns away in bright light |
| <input type="checkbox"/> Fails to visually follow moving objects (6m) | <input type="checkbox"/> Stops & steps/crawls over changes in floor texture or color |
| <input type="checkbox"/> Holds objects/books close to eyes | <input type="checkbox"/> Tilts/turns head to look |
| <input type="checkbox"/> Lacks face regard/eye contact (1/3m) | <input type="checkbox"/> Trips over/bumps into things in path |
| <input type="checkbox"/> Notices objects on one side only (3m) | |
| <input type="checkbox"/> Over or under reaches for objects (5m) | |
| <input type="checkbox"/> Rubs eye(s) | |

VISION CONCERN BEHAVIORS ARE NOTED IN SECTION IV: YES NO

(continued on next page)

V. INTERVIEW QUESTIONS

Taking A Look - 3

Answered by: ___ Mother ___ Father ___ Grandparent ___ Other: _____
(Relationship)

Child's primary caregiver? Yes No

1. What have you noticed about your child's vision within your daily routine? _____

2. At what things does your child like to look? _____

3. Do you have any/additional concerns about your child's vision at this time? Y N
If so, what? _____

VISION CONCERNS ARE NOTED IN SECTION V: YES NO

VI. ADDITIONAL VISION ASSESSMENTS

1. _____ Date _____ By whom? _____ Results _____

2. _____ Date _____ By whom? _____ Results _____

ADDITIONAL ASSESSMENTS REVEAL VISION CONCERNS IN SECTION VI: Y N N/A

VII. RESULTS AND RECOMMENDATIONS

Check one of the following and make indicated recommendation to parent or guardian:

___ NO SCREENING WAS COMPLETED: Child is being followed by an eye doctor and has a medical vision exam report attached to this form. *Send "Screening Results Letter" to parent/guardian, indicating that no screening was completed and why. Provide parent/guardian with "ABCs of 'Red Flag' Vision Problem Indicators" sheet.*

___ PASS: Responses to ALL sections of the screening were "NO". *Send "Screening Results Letter" to parent/guardian. Provide parent/guardian with "ABCs of 'Red Flag' Vision Problem Indicators" sheet.*

___ PASS/
MONITOR: ONLY. A "YES" response was recorded for Section II (Child and Family History). Responses to all other sections were "NO". *Send "Screening Results Letter" to parent/guardian. Give parent/guardian an "ABCs of 'Red Flag' Vision Problem Indicators" sheet. Re-screen child within ONE YEAR.*

___ REFER: A "YES" response was recorded for ANY or ALL of Sections III - VI. *Send "Screening Results Letter" & "Vision Exam Report Form" to parent/guardian. Recommend a referral for a full vision examination by an eye doctor now. Send copy of screening to child's primary care physician. Provide parent/guardian with an "ABCs of 'Red Flag' Vision Problem Indicators" sheet.*

Screener: _____ Title: _____ Phone: _____

Primary care physician: _____ Date last seen: _____

Section I: BACKGROUND INFORMATION

PURPOSE: This section is intended to gather pertinent background and contact information on the child and his/her family.

DIRECTIONS: Information should be gathered from medical and educational records, parent(s)/guardian/family members, early intervention personnel, and other credible written and personal communication sources. Record the information on the form, following the guidelines that follow.

- 1) Date: Record date that checklist was completed.

- 2) County: Record county in which screening was conducted.

- 3) Child's Name: Record full name of child being screened, as it appears on child's medical records.

- 4) DOB: Record child's date of birth (month/day/year).

- 5) Eye Doctor: Record name of child's eye care specialist (doctor specializing in eyes and vision--ophthalmologist or optometrist). If child has not seen an eye doctor, please note "None"; if child has seen an eye doctor, but the name is unknown, please note "Name unknown".

- 6) Seen in Last 12 Months?: Record "Yes" or "No" as to whether or not child has been seen by an eye doctor within the last 12 months.

- 7) Next Visit: Record date of child's next scheduled visit to an eye doctor. If unknown, note "Unknown"; if no appointment scheduled, note "None".

- 8) Diagnosed Vision Problem? Circle "Y" (Yes) or "N" (No).

- 9) If so, What?: Record type(s) of vision problem(s) with which child has been diagnosed.

- 10) Eye Treatment(s): Check "glasses", "meds", "surgery", "patching", "other" and/or "none" based on information in child's medical records and from parent/guardian.

- 11) Other Diagnosed Medical Conditions: Record disabilities and other diagnosed medical conditions, based on child's medical records.

- 12) Current Medications: Record any medications that child is currently taking, based on medical records and parent/guardian report.
- 13) "NOTE: It is unnecessary to screen a child with a diagnosed visual impairment (severe, uncorrectable visual condition) -or- a child followed by an eye doctor who has been seen within the last 12 months - AS DOCUMENTED BY A VISION EXAM REPORT." Attach a copy of the current (within last 12 months) vision exam report (obtained from the child's eye doctor) to the "Taking A Look!" checklist. No further assessment is necessary to document a child's vision status.
- 14) CHECK HERE IF CHILD HAS A DIAGNOSED VISUAL IMPAIRMENT. Check off in the blank to the left if the child has been diagnosed with a(n) (uncorrectable) visual impairment.
- 15) Check here if child's medical vision exam report is attached to this form and no screening was conducted: Check off in the blank to the left. Skip down to "Results and Recommendations" section and check off "NO SCREENING WAS COMPLETED" option. Send "Screening Results Letter" to parent/guardian, with "NO SCREENING WAS COMPLETED" option checked on letter.

Section II: CHILD AND FAMILY HISTORY

PURPOSE: This section is intended to identify a child's potential "risk factors" for a vision concern or impairment, based on the medical history of the child and his/her family members.

DIRECTIONS: Check off those items that are reported for child. Leave blank those items that are not reported. Information should be gathered from medical records and from child's parent(s) / guardian.

- 1) Birth weight less than 3 lbs.: Check if child weighed less than three (3) pounds at birth.
- 2) Cerebral palsy/High or low muscle tone: Check if child has been diagnosed with "cerebral palsy" and/or has high or low muscle tone.
- 3) Child infection at birth: Check if there is evidence that child contracted, or was exposed to, an infection before or at birth. (Examples: TORCH infections - toxoplasmosis, rubella, cytomegalovirus (CMV), herpes, etc.)
- 4) Head trauma: Check if child has ever had a head trauma (injury) that required medical attention.
- 5) Hearing loss: Check if child's hearing is NOT within normal limits.
- 6) Hydrocephaly / Shunt: Check if child has ever been diagnosed with hydrocephaly and/or has ever had a shunt.
- 7) Meningitis / Encephalitis: Check if child has ever had a diagnosis of meningitis or encephalitis.
- 8) Neurological disorder / Seizures: Check if child has ever been diagnosed with a neurological (brain-related) disorder and/or has ever had seizures.
- 9) Prolonged high fever: Check if child has ever had a prolonged, high fever that required medical attention.

- 10) Syndrome with risk of serious vision concern: Check if child has ever been diagnosed with a syndrome that has a high likelihood of including a vision concern or impairment. (Examples: Down syndrome (Trisomy 21), CHARGE association, DeMosier syndrome, Fetal alcohol syndrome, Marfan syndrome, Goldenhar syndrome, Trisomy 13, etc.) See Appendix A, on pages 18-19, for a more comprehensive list of examples.
- 11) Family history includes a member (biological parent, grandparent, aunt/uncle and/or sibling) with a significant vision concern or a visual impairment not due to accident, injury or ageing (generally identified prior to adulthood): Check if any of child's *biological* family members have had a vision problem that was NOT due to accident, injury, or ageing. Most common would be a family member who required a **very strong glasses** prescription as a child ("high myopia" or "high hyperopia"). Other examples include: amblyopia; strabismus; nystagmus; ptosis; color vision deficiency; and retinitis pigmentosa (RP).
- 12) "CHILD AND FAMILY HISTORY RISK FACTORS ARE NOTED IN SECTION II: YES NO": Circle "YES" if item(s) are checked in Section II. Circle "NO" if NO items are checked in this section.

Section III: EYE APPEARANCE

PURPOSE: This section is intended to identify any abnormal or unusual appearances of a child's eyes that are frequently/persistently present.

DIRECTIONS: Check off those items that are observed and/or reported. Leave blank those that are not . Record "N/A" for items that do not apply to child, due to age and/or developmental level. Note "O" for items observed by screener and "P" for those items reported by parent/guardian. Responses to items should be based on parent/guardian/teacher reports of appearances over time and on observations by the person completing the checklist.

If child has glasses, they should be worn, if possible, when observing child for completing this section. Circle "Y" for "With glasses?" if child wore glasses for screening. If child did not wear glasses (will not tolerate wearing glasses, and/or did not have glasses present) during screening , circle "N". If child does not have glasses, circle "N/A".

- 1) Blank/"far away" look to eyes: Check if child's eyes appear to be "looking through" objects or "day dreaming", rather than actively looking at visual stimuli (people and objects) most or all of the time.
- 2) Cloudy or "milky" appearance of eyes: Check if child's eyes are cloudy or "hazy" in appearance. Medical records may note "cataracts".
- 3) Droopy eyelid(s): Check if one or both of child's eyelids "droop" (stay partially closed) most or all of the time. Medical records may note "ptosis".
- 4) Jerky, "wiggling" eyes: Check if jerky or "wiggling" horizontal / vertical movements are observed in one or both of child's eyes. Medical records may note "nystagmus".
- 5) Random/"roving" eye movements: Check if child (BY 2 MONTHS) has eyes that frequently/consistently randomly roll or "roam" and/or do not seem to move together. Record "NA" if child is younger than 2 months of age.
- 6) Red, swollen, or encrusted eyelids: Check if parent reports eyelids are red, swollen, and/or encrusted most of the time (not just due to occasional colds or allergies).

- 7) Squinting/closing/excessive blinking of eyes: Check if child's eyes frequently squint when child is looking, if one or both eye(s) remain closed most of the time and/or if child's eyes blink excessively (frequently and/or very pronounced eye closure) when looking.

- 8) Turning in/out/up/down of one or both eyes: Check if child (BY TWO MONTHS OF AGE) has eyes that frequently/persistently do not seem to be lined up and looking together—e.g., one or both eyes turn in, out, up or down much of the time or, in particular, when child is tired. Medical records may note "esotropia", "exotropia", "esophoria" or "exophoria". Record "NA" if child is younger than 2 months of age.

- 9) Unequal/unusual size/shape of eyes/pupils: Check if eyes or pupils (black center part of eyes) are unequal in size or are, in any other way, unusual in size or shape. (Examples: pupil(s) are not completely round; one eye appears to be larger than the other; one pupil appears larger than the other, one eye missing, etc.) Medical records may note "microphthalmia" or "coloboma".

- 10) Watery, red, or irritated eyes: Check if parent reports child's eyes frequently appear red or irritated or that they water excessively (not just due to occasional colds or allergies)..

- 11) "EYE APPEARANCE CONCERNS ARE NOTED IN SECTION III:
YES NO". Circle "YES" if item(s) are checked in this section.
Circle "NO" if NO items are checked in this section.

Section IV: VISION CONCERN BEHAVIORS

PURPOSE: This section is intended to identify behaviors that could be indicators of vision problems, when exhibited consistently by a child.

DIRECTIONS: Check off those items that have been observed consistently. Leave blank those items that have not. Note "O" for items observed by screener and "P" for those items reported by parent/guardian. Record "N/A" for items that do not apply to child, due to age and/or developmental level. Responses to items should be based on parent/guardian/teacher reports of behaviors over time and on observations by the person completing the checklist.

If child has glasses, they should be worn, if possible, when observing child for completing this section. Circle "Y" for "With glasses?" if child wore glasses for screening. If child did not wear glasses (will not tolerate wearing glasses or did not have glasses present) during screening, circle "N". If child does not have glasses, circle "N/A".

- 1) Covers/closes one eye when looking: Check if child consistently closes one eye, or covers one eye with a hand, when looking at objects or pictures.
- 2) Fails to look at/point to pictures in a book: Check and circle "look at" if child (BY ONE YEAR OF AGE) is not looking at pictures in a book. Check and circle "point to" if child (BY TWO YEARS OF AGE) is not pointing to familiar named pictures or details in pictures. Record "NA" if child is younger than one year and/or cognitively cannot understand what is being asked and/or is physically unable to point. Note: Both "look at" and "point to" may be circled for a two-year-old who is unable to perform either visual task.
- 3) Fails to notice objects above/below head: Check if child (BY THREE MONTHS) consistently fails to look at or attempt to reach for a toy/object presented above or below child's head level, bumps into objects on the floor or overhanging objects when walking, and/or appears surprised when toy/object/person "suddenly appears" in front of face, when object comes toward face from above or below. Record "NA" if child is younger than 3 months of age.

- 4) Fails to visually follow moving objects: Check if child (BY ONE MONTH) makes no attempts to follow close, slowly moving objects, starting at child's eyes and moving to the sides. Check if child (BY THREE MONTHS) is not following a close, slowly moving object, from side to side in front of the child's body. Check if child (BY SIX MONTHS) is not easily and smoothly able to follow moving objects in all directions.
- 5) Holds objects close to eyes: Check if child consistently looks at objects or pictures from a distance of a few inches (or closer).
- 6) Lacks face regard/eye contact: Check and circle "face regard" if child (BY ONE MONTH) does not look toward a familiar person's face. Check and circle "eye contact" if child (BY THREE MONTHS) does not look at the eyes of a familiar adult, or makes only fleeting glances toward adult's eyes, during interactions. Record "NA" if child is younger than one month of age.
- 7) Notices objects on one side only: Check if child (BY THREE MONTHS) consistently notices the presence of food, toys, people, and other objects only on one side, but seems unaware of objects located on the other side. Child may also be observed consistently bumping into objects, walls, or people to one side only while walking. Record "NA" if child is under 3 months of age.
- 8) Over or under reaches: Check if child (BY FIVE MONTHS) consistently is unable to directly and precisely reach for and touch/bat/grasp a stationary object that he/she is looking at. Child may be observed reaching beyond, reaching just short of, or "fishing around" for a desired object before touching it. Record "NA" if child is younger than 5 months of age and/or is physically unable to reach out his/her arms.
- 9) Rubs eye(s): Check if child frequently rubs one or both eye(s). Record "NA" if child is physically unable to rub his/her eyes.
- 10) Seems unaware of distant objects: Check if child (BY SIX MONTHS) consistently seems unaware of people walking at a distance around a room, loses track of a ball or other object that rolls several feet away, and/or does not spot a stationary, familiar person or object from 5-10 feet away. Record "NA" if child is under 6 months of age.

- 11) Seems unaware of self in mirror: Check if child (BY SIX MONTHS) does not look at his/her image in a mirror. Record "NA" if child is under 6 months of age.
- 12) Squints/closes eyes/cries/turns away in bright light: Check if child consistently cries, fusses, shuts eyes, turns head, or shows other signs of discomfort/sensitivity in sunlight or in a lighted room (in which other children and adults appear comfortable).
- 13) Stops & steps/crawls over changes in floor texture or color: Check if child consistently halts body movement when reaching unfamiliar changes in floor textures/colors (i.e. carpet to linoleum or red to black color-- but no steps present) and checks the area with a hand or foot before moving on. Child may also be observed "squatting" and "stepping over" the line where the two surfaces come together. Record "NA" if child is not yet crawling or walking.
- 14) Tilts/turns head to look: Check if child consistently turns his/her head to one side or tilts head up/down/to the side when looking at a person, object, or picture in front of him/her.
- 15) Trips over/bumps into things in path: Check if child consistently stumbles, trips, or bumps into objects in pathway and/or misses floor level changes, such as steps or curbs. Child may appear physically awkward and/or off balance much of the time, with no known physical cause. Record "NA" if child is not yet walking.
- 16) "VISION CONCERN BEHAVIORS ARE NOTED IN SECTION IV: YES NO": Circle "YES" if item(s) are checked in this section. Circle "NO" if there are NO items are checked.

Section V: INTERVIEW QUESTIONS

PURPOSE: This section is intended to elicit direct, open-ended feedback from a child's significant adult(s) about the child's daily visual functioning and adults' concerns.

DIRECTIONS: Interview (in person or by telephone) a parent or other adult who is with the child for significant periods of time. Use written prompts to elicit more detailed information, as needed. Record information in spaces provided.

- 1) Answered by: Check person who is providing answers to the questions in this section. Check "Other" and write in relationship of person to the child if needed.

- 2) Child's primary caregiver? Circle "YES" if the person is responsible for the majority of the child's care. Circle "NO" if not.

- 3) What have you noticed about your child's vision within your daily routine? Use the following questions, as needed, to prompt the person who is responding. It may be unnecessary to ask all of these questions.
 - a) Does your child have/tolerate wearing glasses (if applicable)?
 - b) Does your child seem to see better at certain times of the day (morning, evening, when not tired, etc.)?
 - c) Does your child seem to see better in certain lighting conditions (daylight, nighttime, bright/dim lights, etc.)?
 - d) How close does your child hold objects to see them?
 - e) How close does your child sit to watch TV?
 - f) Does your child turn his/her head to one side when looking?
 - g) Does your child make eye contact with you during conversation or vocal play?
 - h) Does your child seem sensitive to light?
 - i) Does your child seem to notice changes in walking surfaces (e.g., sidewalk to grass; tile to carpeting) and can he/she manage them without difficulty?
 - j) Does your child reach accurately for things (not over or under reaching)?

- 4) At what things does your child like to look? Use the following questions, as needed, to prompt the person who is responding:
- a) Does your child prefer to look at lights, his/her fingers, objects, pictures in books, photographs, etc?
 - b) Does your child search with his/her eyes for a favorite toy?
 - c) Does your child have certain favorite colors? Which ones?
- 5) Do you have any/additional questions or concerns about your child's vision at this time? Yes No If so, what? Person responding may mention things have been observed, such as eye(s) that turn in/out/up/down, eye pressing, excessive tearing, squinting, redness, etc.. Circle Yes or NO, based on responses. Record responses offered.
- 6) "VISION CONCERNS WERE NOTED IN SECTION V: YES NO": Circle "YES" if vision concerns were raised during this interview. Circle "NO" if NO vision concerns were raised during this interview.

Section VI: ADDITIONAL VISION ASSESSMENTS

PURPOSE: This section is intended to report the results of additional vision screening procedures used to determine the child's level of vision.

DIRECTIONS: Additional assessments may be administered by the "Taking A Look!" screener (if trained to do so) OR by another trained professional (eye doctor; nurse, teacher of children who are visually impaired, etc.) and recorded in this section. Additional vision screening components may include:

- a) Photoscreening, such as with an MTI photoscreener.
- b) Preferential Looking Test (PLT), such as Teller Cards, Lea Gratings, and others;
- c) "Cover" Test
- d) "Red Reflex" Test

1) Record the date of the assessment, the name and title of the person who completed it, and the results ("Pass"/"Refer" and comments).

2) "ADDITIONAL ASSESSMENTS REVEAL CONCERNS IN SECTION VI:

"Y N N/A":

Circle "Y" if additional assessments administered revealed concerns.

Circle "N" if additional assessments administered revealed no concerns.

Circle "N/A" if no additional assessments were conducted.

Section VII: RESULTS & RECOMMENDATIONS

PURPOSE: This section summarizes the results of the "Taking A Look!" checklist, with any additional vision assessments that were administered to the child. Based on the results, literature will be provided to the child's parent (describing signs of vision concerns), the child may be monitored carefully for future vision concerns and/or a referral for a medical vision examination (by an ophthalmologist or an optometrist) may be recommended.

DIRECTIONS: Check either "NO SCREENING WAS COMPLETED", "PASS", "PASS/MONITOR" or "REFER", based on the following guidelines:

- 1) Check "NO SCREENING WAS COMPLETED" if:
Child is being followed by an eye doctor and has been seen within the last year, as documented by a vision exam report. Attach the report to the screening form and send a "Screening Results Letter" to the parent(s)/guardian (page 24). Provide parents/guardian with a copy of the "ABCs of 'Red Flag' Vision Problem Indicators" sheet (see Appendix D on page 25).
- 2) Check "PASS" if:
Responses to ALL sections of the screening were recorded as "NO". Send a "Screening Results Letter" to parents/guardian and provide them with a copy of the "ABCs of 'Red Flag' Vision Problem Indicators" sheet (see Appendix D).
- 3) Check "PASS/MONITOR" if:
A "YES" response was recorded for Section II (Child and Family History section) ONLY. Responses to all other sections were "NO". Note: Checking this category indicates that the child is at greater than normal risk for a vision problem to develop, due to child health and/or family risk factors. However, no concerns were noted at the time of the screening. Send a "Screening Results Letter" to parents/guardian and provide them with a copy of the "ABCs of 'Red Flag' Vision Problem Indicators" sheet (Appendix D). Re-screen the child within ONE YEAR.

- 4) Check "REFER" if:
"YES" responses were recorded in ANY or ALL of Sections III through VI. Give or send parents/guardian a "Screening Results Letter", recommending that they contact their primary care physician for a referral to an eye doctor for a full vision examination. Attach a copy of the "Infant-Toddler Eye Examination Report" form to be taken to the eye doctor and returned after the examination is completed (See Sample Form in Appendix E on page 26.) Also give the parent a copy of the "ABCs of 'Red Flag' Vision Problem Indicators" sheet (Appendix D).

It would also be helpful to give the parent/guardian a list of ophthalmologists and optometrists, in the family's home area, who have experience in examining young children (if possible).

- 5) Screeener: Record name of person completing the checklist.
- 6) Title: Record job title/position of person completing the checklist.
- 7) Phone: Record daytime telephone # of person completing checklist.
- 8) Primary care physician: Record name of child's primary care physician (main doctor who treats child). If none, please note "None". Send results of the screening to child's primary care physician.
- 9) Date Last Seen: Record date of child's last office visit to the primary care physician. If unknown, record "Unknown". Use your best estimate, based on family and medical record input.

Appendix A:

SELECTED SYNDROMES WITH
ASSOCIATED VISION CONCERNS

Please note: Vision concerns listed for each syndrome may or may not be present. Each child is different.

CHARGE Association - coloboma.

Cri-du-chat Syndrome - strabismus, myopia, glaucoma, microphthalmos, coloboma, optic atrophy, corneal opacity.

Crouzon's Syndrome - optic atrophy, strabismus, nystagmus.

DeMorsier's Syndrome (septo-optic dysplasia) - nystagmus, optic nerve hypoplasia, associated brain and endocrine abnormalities.

Down Syndrome (Trisomy 21) - strabismus, refractive errors, cataracts, keratoconus, nystagmus, brushfield spots on iris.

Edward's Syndrome (Trisomy 18) - ptosis, glaucoma, microphthalmos, uveal colobomas, corneal opacities.

Ehlers-Danlos Syndrome - dislocation of lens.

Fetal Alcohol Syndrome - strabismus, ptosis, microphthalmos, high refractive error.

Fragile X Syndrome - strabismus, myopia, nystagmus, ptosis, refractive errors.

Goldenhar Syndrome - coloboma, microphthalmos.

Laurence-Moon-Beidel Syndrome - night blindness, tunnel vision, decreased acuity, photophobia, retinal degeneration.

Low Syndrome - cataracts, congenital glaucoma.

Marchesani Syndrome - dislocation of lens.

Marfan Syndrome - dislocation of lens, high myopia, glaucoma, possible retinal detachment.

Pierre Robin Syndrome - glaucoma, retinal detachment, strabismus.

Shaken Baby Syndrome - cortical visual loss, cataracts, vitreal & retinal damage.

Sturge-Weber Syndrome - glaucoma.

Treacher Collins Syndrome - coloboma.

Trisomy 13 - microphthalmos, colobomas, retinal malformations, lens and corneal opacities, optic nerve hypoplasia.

Von Recklinghausen Syndrome (Neurofibromatosis) - ptosis, glaucoma, optic nerve lesions or tumors, strabismus, nystagmus.

Appendix B:

GLOSSARY OF VISION-RELATED CONDITIONS AND TERMS

- Acuity** - the clarity with which an eye sees.
- Amblyopia** ("lazy eye") - decreased vision in an eye without apparent disease; brain "tunes out" this weaker eye and it may progressively lose vision without proper treatment.
- Astigmatism** - see Refractive errors.
- Blindness** - generally refers to no useable vision.
- Brushfield spots** - gray or brown spots on the iris.
- Cataract** - the lens of the eye becomes cloudy or opaque, due to an injury or congenital condition, resulting in decreased vision.
- Cerebral palsy** - damage to the brain that causes reduced ability to coordinate muscles, including muscles used to move the eyes.
- CHARGE association** - a diagnosis for children who exhibit the following group of conditions: coloboma; heart disease; choanal atresia (blockage of the nasal passages); retarded growth and development; genital hypoplasia; and ear anomalies.
- Coloboma** - incomplete development of the eye; may involve one or more parts of the visual system and may cause mild to severe vision problems.
- "Color Vision Testing Made Easy"** - commercially available simple picture red-green color vision test; conducted by a *trained* professional.
- Confrontation Field Test** - screening method for gross field deficiencies, using the examiner's eyes/nose as a fixation point and his/her moving fingers as peripheral targets.
- Corneal opacity** - cloudiness of the clear outer covering of the front of the eye (cornea).
- Cortical visual impairment (CVI)** - damage to the brain that results in reduced ability to interpret visual information.
- "Cover" Test (CT)** - procedures for detecting eye misalignment: *alternate cover test* = cover is shifted from eye to eye and the direction of each eye's movement is noted; *cover/uncover test* = as child views a target, one eye is covered and the other eye is observed for movement, then both eyes are observed for movement when the cover is removed.
- "CSM" (Central, Steady & Maintained)** - eyes fixate centrally, follow objects steadily, and maintain fixation when a target is moved side to side. This notation generally indicates that infants and toddlers have normal visual acuity for their age.
- Cytomegalovirus (CMV)** - virus located in the urinary tract; may cause damage to a fetus prior to birth, including vision problems.

- Encephalitis** - inflammation of the brain.
- Esophoria** - a tendency of one eye to turn inward when it is covered.
- Esotropia** ("crossed eyes") - turning inward of one eye while the other eye looks straight ahead.
- Exophoria** - a tendency of one eye to turn outward when it is covered.
- Exotropia** - turning outward of one eye while the other eye looks straight ahead.
- "Fixes and Follows"** - eyes are able to fixate on visual targets and follow them as they move.
- Functional Vision Evaluation** - evaluation of how a child uses the vision that he/she has; conducted by a *trained* visual impairment educator.
- Glaucoma** - group of diseases characterized by increased pressure inside the eye that causes permanent vision field loss if not treated.
- Herpes** - virus that may cause inflammation or ulcers in the eyes and may affect nerves related to visual functioning.
- "HM" (Hand Motion)** - ability to see a hand as it moves.
- Hydrocephaly (or hydrocephalus)**- when excess fluid collects inside the skull and creates pressure on the brain.
- Hyperopia** - see Refractive errors.
- Iris** - colored portion of the eye.
- Keratoconus** - degenerative corneal disease affecting vision, usually in both eyes.
- "LP" (Light Perception)**- ability to distinguish the presence or absence of light.
- "LProj." (Light Projection)** - ability to determine the *location* of a light source.
- McDowell Vision Screening** - commercially available vision screening instrument for young and developmentally young children; conducted by a *trained* professional.
- Meningitis** - bacterial disease that causes inflammation of a portion of the brain.
- Microphthalmos (microphthalmus; microphthalmia)** - small, underdeveloped eyeball(s).
- Myopia** - see Refractive errors.
- "NLP" (No Light Perception)** - inability to see light (no vision present).
- Night blindness** - reduced ability, or inability, to see in dim lighting conditions and at night.
- Nystagmus** - involuntary, rapid movement ("wiggling") of the eyes.
- Ophthalmologist (M.D.)** - a medical doctor who specializes in diagnosing and treating diseases and disorders of the eye and can perform surgeries to correct some eye problems.

- Optic atrophy** - optic nerve degeneration resulting in irreversible vision loss.
- Optic nerve hypoplasia** - small optic disc (area where optic nerve attaches to the eyeball) and/or small optic nerve, that may affect vision to varying degrees.
- Optic nerve lesions** - abnormal changes in the tissue of the optic nerve due to injury or disease.
- Optometrist (O.D.)** - a doctor of optometry who examines, diagnoses, treats, and manages diseases and disorders of the eye.
- Photophobia** - extreme sensitivity to light.
- Photoscreening** - a screening procedure that involves a special camera that takes a photograph of the eyes; identifies refractive errors, eyes that are not in alignment, and "cloudiness" of the eye(s) that might indicate a vision problem; conducted by a *trained* screener.
- Preferential looking test (or technique) (PLT)** - vision evaluation technique for preverbal children that often uses black and white striped patterns (Examples: Teller Cards; Lea Gratings, and others); conducted by a *trained* professional.
- Ptosis** - drooping of the upper eyelid(s).
- Pupils** - the black circle, or opening, in the center of the eyeball, that is responsible for letting light into the eye.
- Red Reflex Test** - observing for a normal red glow appearance emerging from the pupil when a light is shown into the eye.
- Refractive errors** - a group of visual acuity problems, in which an image is not clearly focused on the back of the eye (Examples: myopia = "nearsightedness" (unclear distance vision); hyperopia = "farsightedness" (unclear near vision); astigmatism (light rays entering the eye are bent unequally); corrected with glasses or contact lenses.
- Retinal degeneration** - degeneration of the retina (back surface of the eye).
- Retinal detachment** - separation of the retina from the cell layer below it; complete detachment results in total blindness in eye.
- Retinitis pigmentosa (RP)** - hereditary, progressive retinal degeneration in both eyes; may create night blindness in childhood.
- Rubella ("German measles")** - may cause vision problems if contracted by a fetus during the first trimester.
- Shunt** - device inserted into a child's brain to drain excess fluid.
- Strabismus** - eye misalignment caused by a neuromuscular disorder.
- Teller acuity cards** - visual acuity test for non-verbal children that assesses their ability to detect black and white stripes of varying widths; conducted by a *trained* professional.

TORCH infections - (toxoplasmosis; rubella; cytomegalovirus; herpes)

Types of organisms that may cause intrauterine infections in pregnant women and may affect their unborn children's vision (common vision condition is optic atrophy).

Toxoplasmosis - infection that may affect lungs, liver, brain, and the retina of the eye.

"Tunnel vision" - loss of peripheral vision; some central vision remains.

Visually evoked response (VER) (or visually evoked potential (VEP)) -

computerized recording of electrical activity in the vision portion of the brain that results from stimulating the retina (back of the eye) with light flashes; used to detect vision problems in the retina-to-brain nerve pathway; conducted by a *trained* eye care professional.

Visual impairment - an uncorrectable vision loss, such as "legal blindness" (visual acuity of 20/200 or less in the best eye with correction (glasses) OR a visual field of 20 degrees or less) or "low vision" (corrected visual acuities ranging from about 20/70 to 20/200). While it is generally not possible to measure precise numerical acuities for infants and toddlers, visual functioning levels can be estimated by medical eye care professionals to document a suspected visual impairment.

Appendix C:

SAMPLE VISION SCREENING RESULTS LETTER

Date: _____

Dear _____,
(Parent(s)/Guardian

Thank you for letting us screen your child's vision today. Vision is a very important part of your child's healthy growth, beginning at birth. Vision screening helps us to identify *possible* vision concerns. It does not replace an examination by an eye doctor.

If a possible concern is identified during the screening, an eye doctor can confirm (or rule out) the presence of a medical vision problem. Because some eye conditions in infancy may not be easily observed through a screening process, eye doctors are now recommending that parents take their children in for a *full medical vision examination* during their preschool years .

The result of your child's screening today is checked below:

_____ NO SCREENING WAS COMPLETED: Your child is already being seen by an eye doctor, so a screening was not conducted.

_____ PASS: No vision concerns were noted today.

_____ PASS/
MONITOR: No vision concerns were noted today. *However, your child may be at a higher than average risk for developing vision concerns, due to his/her health history and/or family history of vision concerns. Please watch carefully for any future concerns. Your child will be re-screened within a year.*

_____ REFER : Possible vision concerns were noted today. *An examination by an eye doctor is strongly recommended now. Please take this letter to your primary care doctor for a referral.*

When you see an eye doctor, please have the attached "Eye Examination Report" form filled out. Return this report form to us as soon as possible. We will help you to find an eye doctor if needed.

Enclosed is an "ABCs of 'Red Flag' Vision Problem Indicators" sheet to help you as you observe the way your child uses his/her vision. If, at any time, you notice a change in your child's vision or have additional questions, please contact your child's doctor or call:

_____ at _____
Service Coordinator/Vision Screener Telephone Number

Thank you.

Appendix D:

ABCs OF "RED FLAG" VISION PROBLEM INDICATORS:
INFANTS & TODDLERS
(Adapted from "Signs of Possible Eye Trouble in Children"
From Prevent Blindness America)

Apppearance

Turning in/out/up/down of one or both eyes (after about 2 months of age).
Crusty, swollen or red eyelids.
Watery, red or irritated eyes.
Eyes that "wiggle" or are in constant random, roving motion.
Droopy eyelid(s).
Pupils of different sizes/shapes or that react to light differently.
Eyes that are of different sizes.
Cloudy or "milky" appearance to eyes.
Excessive squinting, closing or blinking of eyes when looking.
Blank, far-away look to eyes.

Behavior

Covers/closes one eye when looking.
Lack of/reduced eye contact (after about 3 months of age).
Tilts or turns head to look.
Holds books/objects very close to see.
Frowns or squints to see distant objects.
Rubs eyes frequently.
Over or under reaches for objects (after about 5 months of age).
Stumbles or bumps into things and appears awkward.
Stops and steps/crawls over changes in floor texture or color, when no step is there.
Excessive squinting, turning away, or closing eyes to the presence of light.

Complaints

Feeling dizzy or sick to stomach.
Headaches, usually after looking closely at something.
Itching or burning of eye(s).

SAMPLE INFANT/TODDLER EYE EXAMINATION REPORT FORM

Child's Name: _____ D.O.B.: _____
 District/County: _____ School/Program: _____
 Vision Concerns/Diagnoses: _____

Is this child Visually Impaired? Yes No Do not know

Visual Acuties: *Please record whatever acuties are available. If numerical acuity data are not attainable, please indicate best estimates (e.g., NLP, LP, LProj., HM, Fixes & Follows, CSM, or "suspect significant vision problem", etc.).*

	Without Correction		With Correction	
	Distance	Near	Distance	Near
Right Eye	_____	_____	_____	_____
Left Eye	_____	_____	_____	_____
Both Eyes	_____	_____	_____	_____
Test(s) conducted:	<input type="checkbox"/> PLT <input type="checkbox"/> HOTV <input type="checkbox"/> Snellen <input type="checkbox"/> VER <input type="checkbox"/> Other: _____			

Refractive Error: RE: _____ LE: _____

Eyes in Alignment? Yes No Comments: _____

Color Vision Normal? Yes No Comments: _____

Visual Fields Full? Yes No Comments: _____

Condition is: Stable Progressive Fluctuating Uncertain Capable of Improving

Recommendations for Medical Care & Education: _____

Visual Aids Prescribed/Recommended: _____

Last Exam Date: _____ **When do you want to see this child again?** _____

Examiner Name & Title: _____

Address: _____

Phone: _____ **Fax:** _____

Signature: _____ **Date:** _____

Please Return this Form to: Name: _____
 Address: _____

 Phone: _____
 Fax: _____

Thank you.

ACKNOWLEDGMENTS

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The "Taking A Look!" vision screening checklist for infants and toddlers was developed by the following committee members:

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"Never doubt that a small group of thoughtful, committed people can change the world.
Indeed, it is the only thing that ever has."
Margaret Mead

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