LOWER DAUPHIN SCHOOL DISTRICT
KINDERGARTEN REGISTRATION
VISION QUESTIONNAIRE

Child's Name: _____

A. Has your child had a professional eye examination? Yes____ No_____

If yes, list date and by whom: _____

B. Has your child ever had surgery to his/her eyes? Yes ____ No ____

If yes, list date and type of surgery: _____

C. Please check all that apply:

____ Wears glasses	____ Shuts or covers one eye
____ Complains about eyes	____ Tilts head forward
____ Blinks frequently	____ Rubs eyes excessively
____ Squints at objects	____ Holds object close to eyes
____ Either eye turns in or out	____ History of eye problems

Please state details of any above checked items: _____

Screening results: (completed at kindergarten registration)

Near Acuity	Far Acuity	Color Vision	Stereopsis
Right | Left	Right | Left	Right | Left	pass / fail / not done
_____ | _____	_____ | _____	_____ | _____	

Plus Lens
pass / fail / not done

Comments: _____

_____

Referred: Yes: _____ No: _____

Signature of Tester: _____Date:_____

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