Total Optical
Corner Newton & Gatton Sts (Near TAFE) Manunda Ph. 4031 1360

Teacher Questionnaire

Parent/Guardian Release: I _____ (Parent/Guardian Name) grant permission for the release of confidential information regarding my child to Total Optical.

Signed: _____ (Parent/Guardian) Date: _____

CHILD'S NAME: _____ TEACHER'S NAME:_____

SCHOOL:_____ GRADE: _____

SCHOOL POSTAL ADDRESS: _____

Teacher to complete this section:

School and other life activities require children to use two eyes to probe varying distances in the world around them which has a direct impact on their learning and performance in the classroom. This child is attending a developmental optometric evaluation to determine how the various systems of the eyes and body work together as a team at all distances and in space under various demands.

As the teacher of this child, you are in a unique position to have already observed this child in different situations and we would appreciate if you could please complete this questionnaire with as much detail as possible.

In your opinion is this child performing at his/her potential? Yes☐ No☐
Details:_____

Does this child perform better with written tasks or verbal tasks?_____

What are this child's strengths academically? _____

Does this child have any relative weakness academically? _____

What is this child's approximate reading age? _____

Please add any personal impressions you have about this child that may be helpful to our assessment._____

The following is a checklist of symptoms which have been found to be frequently associated with a vision problem. Please read through this list and check those items you have noticed in this child's case.

General Behaviour

- ☐ Complains of headaches
- ☐ Daydreaming or inattentiveness
- ☐ Covers or closes one or both eyes
- ☐ Rubs eyes frequently
- ☐ Avoids close work
- ☐ Blinks excessively
- ☐ Complains of double vision
- ☐ Dislikes tasks requiring sustained visual concentration
- ☐ Irritability or restlessness after close work
- ☐ Frowns, scowls or squints
- ☐ Tilts head to one side

Appearance of eyes

☐ Turned eyes ☐ Watering eyes ☐ Blood shot eyes ☐ Red rimmed or swollen lids

☐ Other:_____

Body posture and spatial

- ☐ Unusual awkwardness
- ☐ Improper or awkward posture while writing
- ☐ Frequent tripping/stumbling
- ☐ Improper or awkward posture while reading

Reading

- ☐ Fatigue when reading
- ☐ Fails to recognise same word in next sentence / paragraph
- ☐ Rubs eyes during or after reading
- ☐ Reads too slowly for age
- ☐ Repeatedly omits small words
- ☐ Complains of letters or lines "running together" or "jumping around" or "swimming"
- ☐ Comprehension poorer with time
- ☐ Skips words or sentences
- ☐ Poor ability to remember what is read
- ☐ Holds reading close
- ☐ Confusion of similar words or letters
- ☐ Moves head while reading
- ☐ Rereads lines or phrases
- ☐ Complains of blur while reading
- ☐ Reverses words

Writing or other desk tasks

- ☐ Difficulty copying from book
- ☐ Slowness copying from book
- ☐ Reverses letters / numbers
- ☐ Holds head too close to desk when writing
- ☐ Difficulty copying from book
- ☐ Slowness copying from board
- ☐ Writes up or down hill
- ☐ Misaligns horizontal and vertical series of numbers
- ☐ Difficulty copying from board
- ☐ Writes crookedly and or poorly spaced
- ☐ Poor hand/eye co-ordination

*Teacher's Signature:*_____ *Date:*_____

Thank you for your time.

Jane Chin Behavioural/Developmental Optometrist