

Glendale Optometric Center

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GLENDALE

Optometric Center

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Fall 2009 Newsletter

It's Back to School time!!! Make sure they're ready



Vision Care Checklist



As a child grows, it is very important to make sure that his or her vision develops normally. Regular eye exams (starting as early as 6 months old) can help parents, teachers and school nurses be certain that a child does not have any signs of vision-related medical problems, such as tumors or eye diseases that could lead to blindness or vision problems that could harm his or her ability to read or learn. Since vision changes can occur quickly and without detection, it is important that a child visit an optometrist **at least** every two years for a comprehensive eye exam, or more frequently if specific problems or risk factors exist.

Do any of the following statements describe the child being tested?

- | | | | | | |
|------------------------------|-----------------------------|--|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Behind a grade level or more in school. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Consistently performs below potential. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Reports sensation of eyes "not working well together." | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tires of near work in a short time. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Bothered by glare from a page. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Reports pain around or in eye at any time. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Complains of blurred vision during reading or writing | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Uses finger as a marker when reading. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Makes frequent reversals when reading or writing. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Red, irritated eyes or lids. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Skips and rereads words and/ or letters. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Excessive tearing of eyes. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Omits or confuses small words when reading. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Frowns, or squints to see. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Turns or tilts head to use one eye only. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rubs eyes frequently. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Avoid close work or detailed activities | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Closes or covers one eye in bright light or during visual tasks. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Reads in dim light. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Loses place while reading. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | After reading or close work, distance vision is blurry | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sees double (two of a single thing). |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Experiences difficulty with eye-hand-body coordination | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Gets headache with eye use. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Holds reading material closer than normal. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | One eye turns inward, outward, upward or downward at any time. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Holds reading material farther than normal. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tends to bump into objects. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sensitive to bright light. | | | |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Print on a page swims, moves, floats, and doubles. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |

If you answered yes to two or more of the statements above, please call our office to schedule an appointment for your child with our optometrists, for further testing. Thank you.