



Birth to 3 Functional Vision Screening Tool

Child's Name: _____ Gender: _____

Date of Birth: _____ Chronological Age: _____ Adjusted Age: _____

County: _____ Agency: _____

Screener Name/Title: _____ Screening Date: _____

Purpose: The Functional Vision Screening Tool is intended to assist a caregiver and early intervention provider in determining when it might be appropriate to refer a child (birth to 3 years old) for vision testing. It is not an assessment nor diagnostic tool for vision issues. It should be administered (in-person or virtually) within 30 days of intake and again every 6 months to identify possible concerns with vision development.

Administration Tips: Most accurate results are obtained by having a silent environment, free from voices or sounds, to ensure you are screening the child's vision, not other senses. Use only a penlight and familiar toys that the child has touched. Remember some of these common indicators that an infant is looking: stopping sucking or moving momentarily, blink response to light, and fixating or locking gaze. It is also important to take a quick look at a child's positioning and consider how it may impact the child's ability to move his/her head or eyes. For example, if a child has a significant head turn to one side, the screener should be adjusting where to present objects at their midline. Infants should be held by a caregiver, while other children should be positioned sitting with support if needed.

Note: Please contact Colleen Kickbush, Vision Services Manager and Teacher of the Visually Impaired (TVI) at Vision Forward, at ckickbush@vision-forward.org for additional information and training.

| Results Summary | |
|--|--|
| Indicate <i>Pass</i> or <i>Refer</i> based on the results of each section of the screening tool. | |
| Family/Birth History and Initial Observations | <input type="checkbox"/> Pass <input type="checkbox"/> Refer |
| Vision Development Checklist | <input type="checkbox"/> Pass <input type="checkbox"/> Refer |
| Comments (Reason for Referral and/or Parent/Provider Concerns): | |
| | |

Results/Action:

- Pass:** Having used this Tool, there are no significant indicators for vision concerns at this time. *Rescreen every 6 months.* **Next Screening Date:** _____
- Refer:** Based on the findings of this screening, it is recommended that the child be referred for a medical and functional vision evaluation (see below).

Date of Referral: _____

Child was referred to BOTH (For resources, Contact [Well Badger Resource Center](#)):

- Pediatric Optometry/Ophthalmology or Pediatrician for vision specialist referral **AND**
- Teacher of the Visually Impaired who conduct Functional Vision Evaluations and provides direct services for children ages 0-3

Family/Birth History and Initial Observations

Based upon caregiver interview and observation of the child, indicate **Yes** or **No** for each question or statement. One or more **Yes** answers in this section are reason for referral. **Exception:** Do not refer upon finding one **Yes** answer in Family/Birth History section alone (except caregiver vision concerns). Child must also have an additional **Yes** answer in another area on the screening tool.

| Family/Birth History | |
|--|--|
| 1. Do the parents/caregivers have concerns regarding vision? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Does anyone in the family have severe vision loss or an eye disease that was diagnosed before the age of 18? (e.g., albinism, amblyopia, cataracts, strabismus, retinoblastoma) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Did the child's mother have any serious infections or diseases during pregnancy? (e.g., rubella, cytomegalovirus (CMV), toxoplasmosis, syphilis, herpes, etc.) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Was the child born prematurely or born weighing fewer than 3 pounds? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Were there any post-natal infections? (e.g., meningitis, encephalitis, hydrocephalus, etc.) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Was there any kind of head trauma at birth or shortly thereafter? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Has any syndrome been identified (e.g. Down Syndrome, CHARGE, Usher, WAGR)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Has cerebral palsy been identified? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Initial Observations: Function | |
| 1. Does not blink to an object coming quickly toward their face. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Demonstrates a preference for one eye by turning/tilting head. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Holds objects far away or unusually close (or moves very close to objects) when looking. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Does not look at people or objects beyond 2 feet. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Frequently trips or crawls/runs into things. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Unable to sustain looking or avoids looking at people or objects. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Squints, cries, or otherwise indicates pain in bright light situations (e.g. sunlight). | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Unable to smoothly follow moving objects in one or more directions with both eyes or there are breaks (e.g. blinking, looking away, or switching eyes) as the object crosses midline. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Initial Observations: Appearance | |
| 1. Eyes are crossed, turn in or out, or move independently of one another...all the time, part of the time, or when the child is tired. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. One or both eyelids droop to cover pupils. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Eyes shake or move constantly. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Iris (colored part of the eye) appears pink or violet. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. One or both of the eye orbits (bone structures around eyes) looks misshaped. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. One or both pupils (black holes in the center of the eyes) are white, cloudy, or any color other than black. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. One or both pupils are not round and appear misshaped (e.g. tear-drop shaped). | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Pupils are unequal in size to each other or there is a delayed reaction to changes in light. | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Vision Development Checklist

For each statement in the child's adjusted age range, check the box to indicate **Yes** or leave it blank to indicate **No**. If there are 2 or more **No** (unchecked) responses in the child's age range, mark **Refer** on the front page under Results Summary.

| Age | Visual Skills |
|-------------------------|--|
| Birth to 1 Month | <input type="checkbox"/> Stares at lights, windows, and bright walls |
| | <input type="checkbox"/> Looks briefly at caregiver's face |
| | <input type="checkbox"/> Gazes briefly at objects placed in field of vision (may stop sucking or moving momentarily) |
| | <input type="checkbox"/> Pupil gets smaller when light is shone in either eye, both pupils get equally larger when lights are turned down |
| | <input type="checkbox"/> Seems to focus best on objects about 8 to 12 inches from face |
| | <input type="checkbox"/> Follows/tracks slowly moving object horizontally with eyes (both eyes not always moving together) |
| 1 to 3 Months | <input type="checkbox"/> Makes eye contact with you (without hearing your voice) |
| | <input type="checkbox"/> Smiles in response to looking into face of a person who is talking or smiling |
| | <input type="checkbox"/> Visually inspects their own hands and nearby surroundings |
| | <input type="checkbox"/> Fixates on objects and high contrast patterns within field of vision |
| | <input type="checkbox"/> Focuses on objects from 5 inches to as close as 3 inches |
| | <input type="checkbox"/> Will turn toward an object brought in from the side |
| 3 to 5 Months | <input type="checkbox"/> Looks at objects/toys in their hands momentarily |
| | <input type="checkbox"/> Visually attends to objects at distances from 5 to 20 inches and views objects at 3 feet |
| | <input type="checkbox"/> Looks at and reaches for most toys within arm's reach |
| | <input type="checkbox"/> Follows or tracks an object vertically or a fast-moving object horizontally |
| | <input type="checkbox"/> Looks back and forth between 2 objects/people |
| | <input type="checkbox"/> Bats at objects that are suspended above him/her |
| 5 to 7 Months | <input type="checkbox"/> Reacts differently to different people and responds to a variety of facial expressions |
| | <input type="checkbox"/> Smiles, pats, or kisses their image in a mirror |
| | <input type="checkbox"/> Laughs at peek-a-boo games |
| | <input type="checkbox"/> Watches people at least 6 feet away |
| | <input type="checkbox"/> Tries to reach out and grasp toys or objects |
| | <input type="checkbox"/> Both eyes are straight and always move together (one eye should not be turning in, out, up, or down. Deviations should be followed medically. Refer to doctor.) |

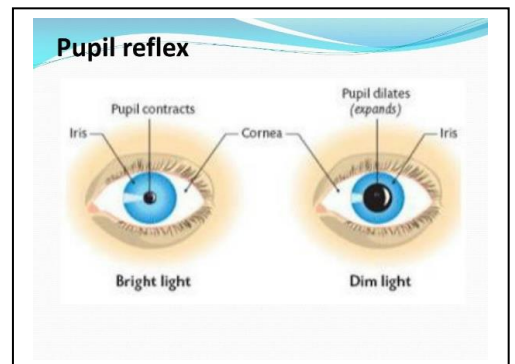
| | |
|-------------------------|---|
| 7 to 12 Months | <input type="checkbox"/> Looks for toys that have been dropped |
| | <input type="checkbox"/> Interested in pictures or picture books |
| | <input type="checkbox"/> Reaches for and tries to pick up a small object like cereal, raisin, or lint |
| | <input type="checkbox"/> Moves, by any means, toward an object at least 5 feet away |
| | <input type="checkbox"/> Tracks objects with eyes rather than just head |
| 12 to 18+ Months | <input type="checkbox"/> Watches a favorite toy dropped into a container |
| | <input type="checkbox"/> Fixates on facial expression and imitates it |
| | <input type="checkbox"/> Looks at distant objects out the window such as cars or people |
| | <input type="checkbox"/> Looks toward indicated objects when requested |
| | <input type="checkbox"/> Turns a book right side up to look at pictures |

Note: Typical vision development is completed at approximately 18 Months; therefore, any Children 18 Months and older should have every visual skill on the checklist.

Definitions and Background Information

Anatomy of the Eye

- **Eyelid**—fold of skin that covers and protects the eye.
- **Iris**—colored part of the eye responsible for controlling the size of the pupil and the amount of light reaching the retina at the back of the eye.
- **Orbit**—the cavity or socket of the skull in which the eyeball is situated.
- **Pupil**—black hole located in the center of the eye that allows light to enter toward the retina at the back of the eye. Pupils should be round, black, and equal in size. Pupils in both eyes should equally and quickly respond to light and change size by getting smaller with light and larger in a darkened room. In darkness, a penlight reflection should be centered or slightly nasal (toward the nose) in BOTH pupils.



Sources: 1) American Association of Pediatric Ophthalmology and Strabismus, 2) Hearing and Vision Connections (2016). Illinois Functional Vision Screening Tool (0-3) by Dr. Mindy Ely. 3) Illinois School for the Visually Impaired (2020). Illinois Functional Vision Screening Tool (0-3). <http://illinoisdeaf.org/Outreach/Screeningtool.html>. 4) Prevent Blindness 5) Wisconsin Department of Health Services Typical Vision Developmental Milestones (Children 0 to 3 Years of Age) 6) Adapted by Colleen Kickbush, Vision Services Manager and Teacher of the Visually Impaired (TVI), in November of 2022. Made possible by a partnership between Vision Forward Association and the Milwaukee County Birth to 3 Program.

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