Clear Form Data

Parent/Caregiver Interview
For Students who are Blind or Visually Impaired

Student Name: _____ Date: _____

Parent/Caregiver Name: _____

Parent e-mail: _____ Phone/Cell: _____

Medical Information/History

What is your understanding of your child's visual impairment and how it affects his/her functioning? _____

_____

_____

_____

Has your child's vision changed in any ways? _____

_____

_____

_____

Has your child had any eye surgeries? _____

_____

When was your child's last eye exam? _____

Name of eye doctor _____

Does your child have a seizure history? Yes ____ No ____ If so, what causes it? _____

Is your child taking any medication? Yes ____ No ____ If so, what? _____

Visual Response

Do you notice any differences in your child's vision on different days or different times of the day? _____

_____

If your child has been prescribed glasses, does your child wear them? Yes ____ No ____ Do the glasses appear to help your child see better? _____

_____

Does your child move his/her glasses forward on the nose or look over then glasses often? _____

How long has your child had his/her present pair of glasses? _____

If your child has been prescribed low vision devices, what are they and how does he/she use them? _____

_____

Describe how your child explores new objects (visually, tactually, auditory, or a combination). _____

_____

_____

What kinds of things does your child appear to see?

Your face……..Yes____ No ____ If so, from what distance? _____
Favorite toys……..Yes____ No ____ If so, from what distance? _____
An object or action during a favorite game……Yes____ No ____ If so, from what distance? _____
Food or drink……..Yes____ No ____ If so, from what distance? _____
An adult moving across the room……..Yes____ No ____ If so, from what distance? _____
TV, windows, lights off or on……Yes____ No ____ If so, from what distance? _____

What types of objects does your child reach for? Please describe this. _____

_____

_____

What is the smallest object you've seen your child try to pick up? _____

Does your child recognize people when they first enter a room without making any sound? How far away are they? _____

_____

Do you notice your child bringing things closer to look at them? Yes ____ No ____ How close? _____

How close does your child generally hold small objects? _____

What kinds of things does your child appear not to see, or have difficulty seeing? _____

_____

What does your child say or do that tells you he/she is having trouble seeing? _____

_____

_____

Are there times your child sees better than others? Yes ____ No ____ If so, when? _____

If your child has been diagnosed as being blind, what do you think that he/she sees? _____

_____

Do you feel that some areas of your child's visual field are better than others? _____

_____

Does your child experience visual fatigue? _____

Does your child have access to a computer at home? Yes ____ No ____ Describe activities the computer is used for, problems encountered, and how far away your child is from the screen. _____

_____

_____

When riding in the car, is your child interested in looking out the window, or does your child usually do other things? _____

_____

Does your child seem to look more at still or moving objects? _____

Describe your child's coloring, drawing, cutting, writing: _____

_____

_____

_____

Response to Lighting

What kind of lighting is best for your child? _____

Is your child sensitive to bright lights? _____

Does your child like to look at room lights or at windows for a relatively long time? _____

_____

Does glare from shiny surfaces bother your child? _____

During Activities of Daily Living

How does your child use his/her vision during mealtimes? _____

Does your child have trouble finding food or knowing what's on the plate? _____

Does your child exhibit age-appropriate skills in daily living activities and chores (eating, dressing, personal hygiene, grooming, etc.)? Yes ____ No ____ Describe _____

_____

How does your child locate things that he/she drops on the floor? _____

_____

During Social Interactions

How does your child use his/her vision to interact with adult and siblings/peers? _____

_____

During Play & Leisure

What are your child's favorite toys? How does your child play with them? _____

_____

_____

What are your child's favorite activities? _____

_____

Does your child like to play computer or video games? _____

_____

Does your child like to look at or read books? _____

_____

What size pictures and font does he/she enjoy reading/looking at? _____

_____

What are your child's favorite colors? _____

_____

Mobility & Travel

Does your child ever have problems getting around in the dark? Yes____ No ____ Explain _____

_____

Does your child have problems with bright light? Yes____ No ____ Explain _____

_____

How does your child adjust to different lighting? _____

_____

Is your child more hesitant to explore or move about in unfamiliar places? Please explain. _____

_____

Does your child have trouble getting around in unfamiliar environments? Yes____ No ____ Explain _____

_____

Does your child have trouble traveling independently outdoors? Yes____ No ____ Explain _____

_____

How does your child use his/her vision to move through the home? Does your child appear to have any difficulty moving about the house? _____

_____

_____

How does your child use his/her vision to move through the yard/playground? _____

_____

Please describe your child's outdoor play activities: _____

_____

How does your child use his/her vision to move on steps/curbs? _____

_____

Miscellaneous

Some children with visual impairments hold their hands near or against their eyes in unusual ways (waving a hand in front of one or both eyes, pressing a hand against an eye). Have you noticed your child doing anything like this? _____

_____

Does your child appear to tilt his/her head in unusual ways to look at things? _____

_____

What type of educational or other services is your child now receiving? _____

_____

Does your child have career goals? Yes ____ No ____ Describe: _____

_____

What are your major concerns about your child's vision? _____

_____

_____

Describe settings or activities of concern in which the teacher of the visually impaired should observe your child? _____

_____

_____

Additional Notes (Comments, Questions, or Concerns)

_____

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