

# About your child and their eyes

easy read form

**SEE ABILITY**

Extraordinary every day

Please fill out as much information as possible.  
Not everything in this form will be relevant to your child.

<b>Child's name:</b>	
<b>Date:</b>	

## It would also be useful to see

Your child's glasses if they have any

The prescription from your child's last eye test

Your child's Health Action Plan or personal records

Prescription					
Name: _____					
Sex: _____					
Age: _____					
	R	I	A	S	A
	Sph	Cyl	Axis	Add	
R	-2.50	+2.00	90		+2.75
L	-2.50	+2.00	90		+2.75
Date: _____					

## Your child's details

<b>Address:</b>	
<b>Phone number:</b>	
<b>Date of birth:</b>	
<b>Ethnicity:</b>	
<b>Name and address of your child's GP:</b>	

## Information about yourself

<b>Name:</b>	
<b>Address:</b>	
<b>Phone number:</b>	
<b>Email address:</b>	
<b>Your relationship with the child:</b>	

## Visits to the Optician

Has your child ever had an eye test at the Optician / Optometrist?

yes  no  don't know

Which Optician / Optometrist?

Date of last check:

Date of next check:

Was your child prescribed glasses?

yes  no  don't know



## Visits to the Hospital

Has your child ever been to see the eye clinic in a hospital?

yes  no  don't know



If yes, what was the problem?

Which hospital did they go to?

Date of last appointment:

Date of next appointment:

Was your child prescribed glasses?

yes  no  don't know



Is your child using their glasses now?

yes  no  don't know

Was your child given patching?

yes  no  don't know

Did your child have an operation on their eyes?

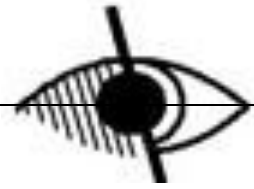
yes  no  don't know

Is your child registered blind / severely sight impaired?

yes

no

don't know



Is your child registered partially blind / sight impaired?

yes

no

don't know

Is your child using their glasses now?

yes

no

don't know

Does your child have any problems with their glasses?

yes

no

don't know

Comments:

Do you have any concerns about your child's eyes?

yes

no

don't know



If yes, please write what the problems are:

Is there a history of blastoma in your family?

yes

no

don't know

### Other useful information

**Has anyone in your family had eye problems?**

yes

no

don't know



For example has anyone needed to wear glasses as a child, had a squint / strabismus, patching one eye or an eye condition or blastoma?

If yes, please write who has had problems and what problems they've had:

Who	What problem

Do your child's eyes always appear straight?

yes           no           don't know

If one/both eyes appear to wander, which eye does this and how often?  
Do your child's eyes ever appear to move excessively rapidly or uncontrollably? Do you think your child has trouble controlling his/her eye movements? *If so please give details if possible:*

Does your child complain of headaches?

yes           no           don't know

Does your child tend to shut one eye?

yes           no           don't know

Does your child appear very sensitive to bright lights?

yes           no           don't know

### More about your child

Does your child use a wheelchair?

yes           no           sometimes

Does your child have any health problems or disabilities?

yes           no           sometimes



If yes, please say what they are:

## Birth history

Please give details of any difficulties with your pregnancy or child's birth.

(i.e: mother having infection, prematurity, low birth weight, need for special care etc)

Does your child take any medication?

yes       no       don't know



If yes, please take information about your child's medication with you to the eye test and list them below:

Does your child have any allergies?

yes       no       don't know

If yes, please list them below:

Is your child deaf or hard of hearing?

yes       no



If yes, please tell the optometrist about your child's hearing:

Does your child find it hard to communicate?

yes       no       sometimes

What helps your child to communicate? Tell us if you use things like:

Makaton                      yes  no

An interpreter    yes         no

Pictures                    yes         no

Gestures                    yes         no

Other (please describe how you communicate with your child):

## About your child's eyes



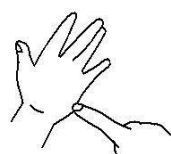
When your child has their eye test the optometrist will need to look at their eyes. They will also do some tests to check how well they can see.

The information you give the optometrist will help them to test your child's eyes.

Can your child say or sign the names of letters on any eye test chart?



← T →

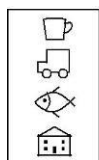


yes

no

don't know

Can your child say or sign the names of pictures on a chart like **house**, **fish** or **car**?



← House →

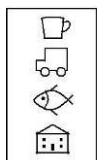


yes

no

don't know

Can your child point to a letter or picture on a card that is the same as a letter or picture on a chart on the wall?



yes

no

don't know

Will your child be able to wear test frames on their face?

yes

no

don't know



Will your child be okay if the optometrist were to cover their eyes one at a time?

yes  no  don't know

Can your child understand '**better**' and '**worse**'?

yes  no  don't know



**better**



**worse**

Will your child be okay if the optometrist comes close to them and shines a bright light in their eye?

yes  no  don't know



Will your child be okay if the optometrist puts drops in their eyes? Some eye drops may sting for a bit, or make it hard to see for a short time. You can ask the optometrist about this.

yes  no  don't know



## Five key questions

**We would also like you to consider the following five questions. These questions are designed for a range of ages and abilities, so some questions may not be relevant. Your child may have difficulty with some behaviours listed below but not others – this is normal. You may also notice that some of the behaviours described occur only occasionally or more frequently when your child is tired, this is common.**

**Tick the box which best describes your child's current behaviour and if for example your child uses a wheelchair and the stairs question is not relevant, ring "not applicable".**

**1. Does your child have difficulty walking downstairs?**

Never	Rarely	Sometimes	Often	Always	Not applicable
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**2. Does your child have difficulty seeing fast-moving objects?**

Never	Rarely	Sometimes	Often	Always	Not applicable
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**3. Does your child have difficulty seeing something that is pointed out in the distance?**

Never	Rarely	Sometimes	Often	Always	Not applicable
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**4. Does your child have difficulty locating an item of clothing in a pile of clothes?**

Never	Rarely	Sometimes	Often	Always	Not applicable
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**5. Does your child find copying words or pictures time-consuming and difficult?**

Never	Rarely	Sometimes	Often	Always	Not applicable
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Please tell us any other information we may need to know:



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