WIDE RUINS
COMMUNITY SCHOOL
FAMILY AND CHILD EDUCATION PROGRAM
P.O. Box 309, Chambers, Az 86502 Phone: (928) 652-3251 Fax: (928) 652-3286 https://kinteelolta.org/

ENROLLMENT: _____

F.A.C.E. ENROLLMENT APPLICATION
SY 2023-2024

"Parents are their child's first and most influential teachers"

Mission: Wide Ruins Community School will provide academic excellence and cultural awareness for our children.

The following information and documents are needed for each student at the time of enrollment. Students will not be permitted to start school until all the required documents have been received and completed.

ENROLLMENT FORMS: ***Pre-K/K-3rd is Onsite ONLY, No Virtual Platform this SY 23-24.***

- ☐ 1. Completed enrollment application *(this is for actual enrollment to be counted):*
  - ☐ Child(ren) and
  - ☐ Adult(s) / Caregiver
- ☐ 2. Emergency Contact and Permission to Release
- ☐ 3. Media Release
- ☐ 4. Location of Home/Map
- ☐ 5. Child Health Record *(Fill this out as completely as possible)*

REQUIRED VITAL DOCUMENTS TO BE TURNED FOR ENROLLMENT:

- ☐ 1. Birth Certificate
- ☐ 2. Certificate of Indian Blood (CIB)
- ☐ 3. Immunization Record – Updated (Child/ren)

OTHER FORMS UPON APPROVAL OF ENROLLMENT: *(Will be provided by FACE Staff)*

- ☐ 1. Child Permission to screen / Transition Plan
- ☐ 2. Adult Learner Interview / Adult Participation Plan / Technology Self-Assessment / Student Goal Tracking Form / Updated Progress Towards Goals
- ☐ 3. Homebase forms as given by Parent Educators.

Lastly, upon your submission of enrollment application, the FACE Coordinator will review and ensure all forms and vital records are attached. If so, the FACE Coordinator will send an email to you and the program which you will participate and be enrolled. ***If not approved, you will be informed of incomplete application and what needs to be turned into the FACE Program.***

FACE Coordinator: Ms. Jeannie M. Lewis

If you should have any questions, please feel free contact our FACE Program at (928) 652-3251 ext. 106 or via email to any FACE Staff: s.james@kinteelolta.org , N.noble@kinteelolta.org, e.lewis@kinteelolta.org, d.robinson@kinteelolta.org, j.lewis@kinteelolta.org

Enrollment Form for BIE FACE Program Evaluation—Child Information

Program Year 2024 (July 1, 2023– June 30, 2024)

FACE school: _____ Date (mo/day/yr) __-__-____

Child's name *First:* _____ *Last:* _____

Child's NASIS # _____ Child's Tribal Affiliation: _____

Child's date of birth: __-__-____ ◯ Male ◯ Female

Prenatal (unborn) child? ◯ Yes ◯ No Due date: __-__-____

Is this child enrolled in elementary school? ◯ Yes ◯ No If yes, what grade? ____

1. With whom does this child live? **Fill in all that apply.**

☐ Mother ☐ Father ☐ Grandparent ☐ Foster Parent ☐ Other Relative ☐ Other Non-relative

2. How many people live in the child's home? (Include this child in the counts.) Total number: ____

Number of children aged birth to 5 years	____
Number of children aged 6 to 8 years	____
Number of children aged 9 to 13 years	____
Number of children aged 14 to 17 years	____
Number of adults aged 18 or older	____

2. Please provide information about the child's household

	Female head of household	**Male head of household**
Name	_____	_____
Relationship to child	_____	_____
Hours per week employed	_____	_____
Highest grade completed	_____	_____
Currently attending school?	Yes ◯ No ◯	Yes ◯ No ◯

3. Does the family with whom the child is living receive public assistance from a tribal, state, or federal agency?

◯ Yes ◯ No

If yes, fill in all that apply: ☐ TANF ☐ SNAP/Food stamps ☐ Other

4. What language is spoken in the child's home? (Fill in all that apply)

English ☐ Native ☐ Other ☐ (specify)_____

What is the primary or most frequently spoken language in the child's home? (Fill in one.)

English ☐ Native ☐ Other ☐ (specify)_____

5. About how many children's books are in this child's home? (Fill in one.)

None ◯ About 5 ◯ 6-10 ◯ 11-20 ◯ 21-30 ◯ 31-50 ◯ 51-99 ◯ 100 or more ◯

6. About how many books for adults are in this child's home? (Check one.)

None ◯ About 5 ◯ 6-10 ◯ 11-20 ◯ 21-30 ◯ 31-50 ◯ 51-99 ◯ 100 or more ◯

Enrollment Form for BIE FACE Program Evaluation—Adult Information

Program Year 2024 (July 1, 2023– June 30, 2024)

This form is to be completed by the enrolling adult at the time of enrollment or re-enrollment in PY24. Responses will remain confidential.

FACE school: Wide Ruins Community School Date (mo/day/yr) __-__-____

Adult's Name: *First:* _____ *Last:* _____

Adult's NASIS # _____ Adult's Tribal Affiliation: _____

Adult's date of birth (mo-day-yr) __-__-____ ◯Male ◯Female

Mailing Address _____ Your phone number (___) ___-____

Physical Address _____ Email address: _____

Name and phone number of a contact: _____ (___) ___-____

1. Child(ren) you are enrolling in FACE:

Name(s) of Children You are Enrolling in FACE	Your relationship to child	Do you live with this child? *Yes*	Do you live with this child? *No*	Age of Child
Child1 _____	_____	◯	◯	_____
Child2 _____	_____	◯	◯	_____
Child3 _____	_____	◯	◯	_____

Prenatal (unborn) child ◯Yes ◯No Due date: __-__-____

2. Please describe why you are enrolling yourself and your child in FACE (fill in all that apply):

- ☐ To improve my parenting skills
- ☐ To understand child development
- ☐ To prepare my child for school
- ☐ To help my child get along with others
- ☐ To be more involved with my child's school
- ☐ To help me obtain a GED or high school diploma
- ☐ To improve my academic skills so I can go to college/technical school or get other training/education
- ☐ To help me with my college/technical school coursework
- ☐ To improve my reading skills
- ☐ To improve my employability skills
- ☐ To get a job
- ☐ To make friends
- ☐ To improve my family's well-being
- ☐ To obtain help in identifying and accessing resources for family and individual support
- ☐ To improve my Native language skills and cultural knowledge
- ☐ Other (describe) _____

FACE Enrollment Form for Adults—Page 2

3. What is the highest grade/educational level you have completed? _____?

Below, please fill in **each** educational experience you have had.

- ☐ Received a high school diploma
- ☐ Completed a GED
- ☐ Attended a job training program
- ☐ Completed some college course(s): __ credit hours
- ☐ Received a certificate (describe): _____
- ☐ Received a 2-year Associate Degree
- ☐ Received a Bachelor's Degree
- ☐ Received a Master's Degree
- ☐ Other: _____

4. Are you currently attending school (other than FACE adult education)? ◯Yes ◯No

5. Are you currently employed? ◯Yes ◯No
   If yes, approximately how many hours a week do you work? ____ *hours per week.*

6. Do you currently receive financial assistance from a state, federal, or tribal agency? ◯Yes ◯No
   If yes, Check all that apply: ☐TANF ☐SNAP/Food stamps ☐Other

7. How well do you do each of the following? (fill in all that apply)

	Not at all	**Not very well**	**Pretty well**	**Very well**
Speak English?	◯	◯	◯	◯
Read English?	◯	◯	◯	◯
Write English?	◯	◯	◯	◯
Understand someone speaking English?	◯	◯	◯	◯
Speak your Native American Indian language?	◯	◯	◯	◯
Read your Native American Indian language?	◯	◯	◯	◯
Write using your Native American Indian language?	◯	◯	◯	◯
Understand someone who speaks your Native American Indian language?	◯	◯	◯	◯

WIDE RUINS COMMUNITY SCHOOL

FAMILY AND CHILD EDUCATION PROGRAM

P.O. Box 309, Chambers, Az 86502 Phone: (928) 652-3251 Fax: (928) 652-3286

www.kinteelolta.org

Permission to Release Child

Child's Name _____ **Date of Birth** _____ **Male** ___ **Female** ___

I. Permission to Release Child: Beside the parent/guardian, the following person(s) can be called in case of an emergency. I give the FACE program and school permission to release my child to the following person(s) on my behalf. Contact and check out person(s) must be 18 years or older and bring proof of identity with them.

	Name	Relationship to the Child	Phone Number
1.			
2.			

I understand when my child is released to the above person(s), the FACE program and school are relieved of all responsibilities for the care and safety of my child. My child will not be released to anyone whose name is not entered on this sheet. I also understand that changes must be in writing to the school and FACE program. Picture ID will be required by the office staff.

Parent/Guardian Signature: _____ **Date:**_____

Emergency Contact and Health Information

Adult's Name: _____

II. Emergency Contact: In the event anything should happen to me (the adult in FACE), please contact the following Person(s):

	Name	Relationship to the Child	Phone Number
1.			
2.			

III. Medical History: Please circle our answer if you (the adult student) have any of the following, now or in the past:

Breathing Problems/Asthma	Yes	No
Seizures	Yes	No
Fainting (Frequent)	Yes	No
Headaches (Frequent or severe)	Yes	No
Diabetes/Pre-Diabetes	Yes	No

Heart Murmur/Heart Disease	Yes	No
High Blood Pressure	Yes	No
Hearing Problems/Hearing Aids	Yes	No
Vision Problems/Glasses/Contacts	Yes	No
Other:	Yes	No

Medication: Do you take any medication that you may need to be given in an emergency situation? ☐ Yes ☐ No
If you circled yes, what are the medications for? _____

Health Care: Do you have any health care needs? ☐ Yes ☐ No
If you circled yes, what are they? _____

Allergies: Do you have any allergies? ☐ Yes ☐ No
If you circled yes, what are they and what happens? _____

Adult Signature _____ **Date** _____

Please Print Name _____

Family And Child Education

Media Release Form

I hereby grant to the Bureau of Indian Education (BIE), Parents as Teachers National Center (PAT) and the National Center for Families Learning (NCFL), or anyone authorized by them, including without limitation any of their partners or affiliates, the right to copyright and use my name, likeness, image, voice, story, appearance, performance, and artwork to record or transfer to video tape, film, slides, photographs, audio tape, print, on-line courses, or other media now known or later developed.

I hereby waive any right I may have to inspect and approve the finished product, or the advertising or other copy that may be used in connection therewith or the use to which it may be applied.

I hereby release and discharge the BIE, PAT or NCFL and all persons acting under their permission or authority, from any liability by virtue of any blurring, distortion, alteration, optical illusion, or use in composite form, whether intentional or otherwise, that may occur or be produced in any process tending toward the completion of the finished product.

I understand that this product will be used for broadcast, exhibit, market, sale or other distribution and the BIE, PAT and NCFL have no financial commitment or obligation as a result of this agreement.

I have read this agreement and I understand what I am signing.

FACE Program_____ Date_____

Name of Parent/Guardian (please print) _____

Name of Child(ren) (please print) _____

Address_____

Email Address_____

In the case of a minor, the signature and date of the parent or guardian is required.

Parent/Guardian name_____ Date_____

Signature_____

**Center-based FACE Staff: Fax signed copy to National Center for Families Learning, 502-805-0593*
**Home-based FACE Staff: Fax signed copy to Parents as Teachers National Center, 314-432-8963*

Parents as Teachers National Center
2228 Ball Drive • St. Louis, MO 63146 • (314) 432-4330
National Center for Families Learning
325 West Main Street, Suite 300 • Louisville, KY 40202 • (502) 584-1133

WIDE RUINS COMMUNITY SCHOOL

FAMILY AND CHILD EDUCATION PROGRAM

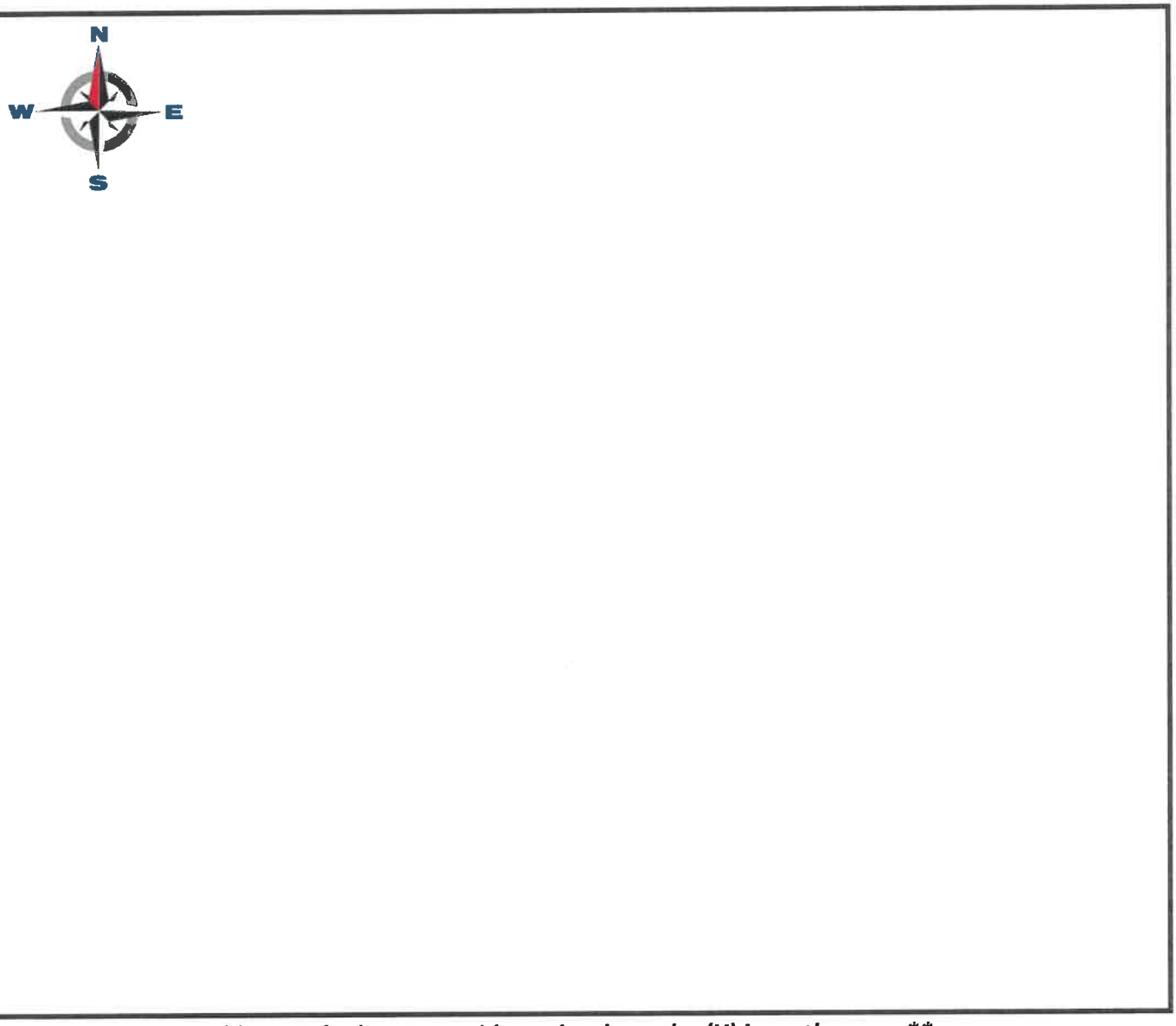
P.O. Box 309, Chambers, Az 86502 Phone: (928) 652-3251 Fax: (928) 652-3286

www.kinteelolta.org

LOCATION OF HOME (MAP)

Child's Name _____ **Date of Birth** _____ **Male** ___ **Female** ___

I. Location of Home/Map: We require a physical location of home/map, to make deliveries and pick up/drop off, if needed. Please be as specific as possible.



***** I certify that my residence is where the (X) is on the map.*****

Parent/Guardian Signature _____ **Date** _____

Please Print Name _____

Parents as Teachers.

Child Health Record

Child's name: _____ Due date/birth date: _____

Gender: _____ Form completion date: _____

Adjusted age of child in months (for children up to 3 years of age who were born preterm): _____

Is this the first Child Health Record? ☐ Yes ☐ No

Pregnancy history

Prenatal

Dates of prenatal care visits to obstetrician: _____

Mother uses/used folic acid supplements during pregnancy?
☐ Yes ☐ No

Frequency of folic acid use (select one):
☐ 2 or fewer times per week ☐ 3 to 4 times per week
☐ 5 or more times per week

Mother uses/used vitamin supplements during pregnancy?
☐ Yes ☐ No

Frequency of vitamin use (select one):
☐ 2 or fewer times per week ☐ 3 to 4 times per week
☐ 5 or more times per week

Baby exposed to neurotoxins before birth? (check all that apply):
☐ Alcohol ☐ Amphetamines ☐ Barbituates ☐ Caffeine ☐ Cocaine/crack ☐ Inhalants ☐ Marijuana
☐ Mercury ☐ Nicotine/cigarettes ☐ Opioids/heroin ☐ Pesticides
☐ Other (please specify): _____

Mother diagnosed with (check all that apply):
☐ Ectopic pregnancy ☐ Gestational diabetes ☐ Low amniotic fluid ☐ Preeclampsia ☐ Placenta previa
☐ Other (please specify): _____

High-risk pregnancy?
☐ Yes ☐ No

Did this pregnancy result in (check one):
☐ Miscarriage ☐ Stillborn birth ☐ Live birth

Pregnancy notes:

Parents as Teachers.

Labor and delivery

Type of delivery: ☐ Caesarean section ☐ Vaginal Difficulty? ☐ Difficulty during labor ☐ Difficulty during delivery

Birth weight: _____ pounds _____ ounces Weeks of gestation (when baby was born): _____

Special conditions at birth (check all that apply):
☐ Congenital heart disease ☐ Jaundice ☐ Spina bifida ☐ Down syndrome ☐ Sickle cell anemia
☐ Other (please specify): _____

Postpartum

Only need to answer if child is 12 months or younger.

Child was breastfed? ☐ Yes ☐ No

If yes: How long was the child breastfed? ☐ Less than 3 months
☐ 3 to 5 months ☐ 6 to 9 months
☐ More than 9 months ☐ Still in progress

Where was breastfeeding initiated?
☐ In the hospital ☐ In the home

Is child exclusively breastfed?
☐ Yes ☐ No

Date(s) of postpartum visit(s):
_____ _____ _____ _____

Health Review

Medical visits and conditions

Dates of well-child visits

5 days		9 months		2.5 years (30 months)	
1 month		12 months		3 years	
2 months		15 months		4 years	
4 months		18 months		5 years	
6 months		2 years (24 months)			

Parents as Teachers.

Immunizations up to date? ☐ Yes ☐ No Date last received immunizations: _____

If not up to date, please specify why not: _____

Primary location for child's regular medical checkups and sick care (select one):

☐ Doctor's/nurse practitioner's office ☐ Hospital emergency room ☐ Hospital outpatient
☐ Federally qualified health center ☐ Retail store or minute clinic ☐ Unknown/did not report ☐ None
☐ Other (please specify): _____

Child has had any illness with high fever (104°F or more) longer than two days. ☐ Yes ☐ No

Medical conditions (check all that apply):

☐ Acquired immunodeficiency syndrome (AIDS)
☐ Asthma and respiratory allergies
☐ Cancer
☐ Cerebral palsy
☐ Cystic fibrosis
☐ Diabetes
☐ Digestion disorders
☐ Emotional/mental health disorders
☐ Feeding difficulties in early childhood
☐ Fetal alcohol spectrum disorder (FASD)
☐ Genetic disorders
☐ Hearing impairment
☐ Heart disease/defects
☐ Human immunodeficiency virus (HIV)
☐ Juvenile arthritis
☐ Overweight and obesity
☐ Prematurity and low birth weight
☐ Sickle cell disease
☐ Spina bifida/neural tube defects
☐ Visual impairment
☐ Other (please specify): _____

Developmental conditions (check all that apply):

☐ Acquired brain injury and selected neurological disorders
☐ Attention deficit hyperactivity disorder (ADHD)
☐ Autism spectrum disorders (ASD)
☐ Communication, language, and speech disorders
☐ Developmental disabilities – not otherwise specified
☐ Disruptive behavior disorders
☐ Learning disabilities
☐ Motor delay and movement disorders
☐ Sensory processing disorder
☐ Other (please specify): _____

Allergies (check all that apply):

☐ Environmental ☐ Food ☐ Medicines ☐ Other (please specify): _____

Child's health insurance (check all that apply):

☐ No insurance coverage ☐ TRICARE ☐ Unknown ☐ No insurance, accessing Indian Health Service
☐ Title XIX (Medicaid/Title XXI – state children's insurance program) ☐ Private or other ☐ Did not report

Parents as Teachers

Emergency room visits

Date of visit: _____

Reason for visit:
☐ Injury ☐ Illness ☐ Poison
☐ Other (please specify): _____

Referred by health care professional: ☐ Yes ☐ No

Date of visit: _____

Reason for visit:
☐ Injury ☐ Illness ☐ Poison
☐ Other (please specify): _____

Referred by health care professional: ☐ Yes ☐ No

Date of visit: _____

Reason for visit:
☐ Injury ☐ Illness ☐ Poison
☐ Other (please specify): _____

Referred by health care professional: ☐ Yes ☐ No

Date of visit: _____

Reason for visit:
☐ Injury ☐ Illness ☐ Poison
☐ Other (please specify): _____

Referred by health care professional: ☐ Yes ☐ No

Medicines and supplements taken regularly (check all that apply):
☐ Over-the-counter drugs ☐ Ear drops ☐ Vitamin supplements ☐ Antibiotics ☐ Eye ointment
☐ Asthma inhalers ☐ Other (please specify): _____

According to the health care provider, are child's size and weight OK? ☐ Yes ☐ No

If no, please specify concerns about child's size or weight: _____

Child has been screened for anemia? ☐ Yes ☐ No

If yes, please specify results of anemia screening: _____

Child has been screened for lead levels? ☐ Yes ☐ No

If yes, please specify results of lead screening: _____

Parents as Teachers.

Dental review

Brushing teeth, flossing, and/or cleaning gums is part of the child's daily routine? (select one):
☐ Always ☐ Sometimes ☐ Never

Child falls asleep with a bottle? (select one): ☐ Always ☐ Sometimes ☐ Never

Parent has concerns about the child's teeth or gums? ☐ Yes ☐ No
If yes, please specify concerns about teeth or gums: _____

Child has a source of dental care? ☐ Yes ☐ No Child has regular dentist appointments? ☐ Yes ☐ No
Child had his/her first dental appointment? ☐ Yes ☐ No

According to the American Academy of Pediatric Dentistry, a dental home enhances the dental professional's ability to assist children and their parents in the quest for optimum oral health care, beginning with the age 1 dental visit for successful preventive care and treatment as part of an overall oral health care foundation.

Safety review

For children up to 12 months

Does child bed-share? (select one): ☐ Always ☐ Sometimes ☐ Never

Is child placed on his/her back to sleep? (select one): ☐ Always ☐ Sometimes ☐ Never

Is there soft bedding in the area the child sleeps in? (select one): ☐ Always ☐ Sometimes ☐ Never

For all children

Is child exposed to secondhand smoke? (select one): ☐ Always ☐ Sometimes ☐ Never

Notes regarding secondhand smoke exposure: _____

Parents as Teachers®

Safety review (continued)

- ☐ There is at least one working smoke detector on each floor where the family resides.
- ☐ Child rides in an approved car seat according to state law.

General guidelines: Rear-facing safety seat in the back seat from birth to age 2 and forward-facing safety seat in the back seat until at least age 5.

- ☐ If child is involved in biking, skating, riding a scooter, or similar device, a helmet is used.
- ☐ Home is childproofed (for example, to prevent accidental poisoning, choking, and other injuries).
- ☐ Family has a plan and supplies in case of an emergency in the home or natural disaster.

Date Health Review completed: _____

Parents as Teachers.

Hearing Review

Hearing review

For children up to 12 months (select one):

Child had a new born hearing screening?	☐ Yes	☐ No	☐ Parent/guardian is unsure

If parent/guardian indicates child did not have a new born hearing screening or is unsure, the parent educator should help the parent/guardian follow up.

If yes: Newborn hearing screening record obtained	☐ Yes	☐ No	
Newborn hearing screening results:	☐ Pass	☐ Fail	☐ Unknown
Newborn hearing screening follow-up recommended?	☐ Yes	☐ No	
Newborn hearing screeing follow-up obtained?	☐ Yes	☐ No	☐ N/A

Additional information: _____

For all children

Child has had ear infections? ☐ Yes ☐ No

If yes, number of ear infections:
☐ 1 or 2 times ☐ 3 or 4 times ☐ 5 or 6 times
☐ 7 or more times

What were the treatments?
☐ Antibiotics ☐ Ear tubes
☐ Other (please specify): _____

Child's hearing has been checked by a health care provider in the last 12 months: ☐ Yes ☐ No

Results of the hearing check: _____

Child has had an audiology exam in the last 12 months:
☐ Yes ☐ No

Date of the latest audiology exam: _____

Who did the audiology exam?

_____

Documentation of the audiology exam obtained?
☐ Yes ☐ No

Results of the audiology exam: _____

Parents as Teachers

Hearing review (continued)

Answer questions 1 through 8 for children under 2 years; answer questions 6 through 12 for children 2 years and older.

1. Reacts to sudden loud noises.	☐ Yes	☐ No
2. Turns head toward interesting sounds or when name is called.	☐ Yes	☐ No
3. Coos to himself and makes noise when he is alone.	☐ Yes	☐ No
4. Uses voice to get attention.	☐ Yes	☐ No
5. Tries to imitate you if you make his own sounds.	☐ Yes	☐ No
6. Seems to hear you if you talk in a whisper.	☐ Yes	☐ No
7. Seems to speak as well as other children the same age.	☐ Yes	☐ No
8. Has a family history of hearing problems.	☐ Yes	☐ No
9. Seems to have difficulty hearing.	☐ Yes	☐ No
10. Needs the television louder than other members of the family.	☐ Yes	☐ No
11. Seems to favor one ear over the other.	☐ Yes	☐ No
12. Makes you talk loudly or repeat frequently.	☐ Yes	☐ No

A "no" answer for items 1 through 7 indicates the need for discussion and follow-up. A "yes" answer for items 8 through 12 indicates the need for disucession and follow-up.

Parents as Teachers.

Audiology tests (optional)

Screening tool:	Administered by (select one):	Date Completed:	Left ear (select one):	Right ear (select one):
OAE	☐ Parent educator ☐ Supervisor ☐ Contracted screener ☐ Health care provider		☐ Can't test ☐ Refer ☐ Pass	☐ Can't test ☐ Refer ☐ Pass
Tympanometry	☐ Parent educator ☐ Supervisor ☐ Contracted screener ☐ Health care provider		☐ Can't test ☐ Refer ☐ Pass	☐ Can't test ☐ Refer ☐ Pass
Audiometry	☐ Parent educator ☐ Supervisor ☐ Contracted screener ☐ Health care provider		☐ Can't test ☐ Refer ☐ Pass	☐ Can't test ☐ Refer ☐ Pass

Note: OAE, tympanometry, and/or audiometry can be beneficial but are not required to meet the PAT Essential Requirements.

Comments/suggestions:

Date Hearing Review completed: _____

Parents as Teachers

Vision Review

Vision review

Child had an eye exam by a pediatrician, eye doctor, or other qualified professional in the last 12 months? ☐ Yes ☐ No

Date of latest eye exam: _____ Who did the eye exam? _____

Results of the eye exam: _____

Documentation of the eye exam obtained? ☐ Yes ☐ No

The child:

1. Has eye crossed – turning in or out – at any time, or eyes that do not appear straight, especially when child is tired.	☐ Yes	☐ No
2. Has reddened eyes or eyelids.	☐ Yes	☐ No
3. Has encrusted eyelids.	☐ Yes	☐ No
4. Has frequent styes (pimples on the eyelid).	☐ Yes	☐ No
5. Has eyes that appear to move more than other people's eyes do.	☐ Yes	☐ No
6. Has eyelids that droop.	☐ Yes	☐ No
7. Has white spots or cloudiness covering some or all of the center of the eye.	☐ Yes	☐ No
8. Complains of burning, itching, or pain in the eyes.	☐ Yes	☐ No
9. Stares at bright lights frequently or repeatedly flicks objects in front of face.	☐ Yes	☐ No
10. Is bothered by light more than you are.	☐ Yes	☐ No
11. Exhibits a pupil (the dark center of the eye) that seems larger or smaller than the pupil in other children's eyes.	☐ Yes	☐ No
12. Complains of headache or nausea.	☐ Yes	☐ No

A yes answer for any item 1 through 12 indicates the need for discussion and follow-up.

Parents as Teachers®

Vision review (continued)		
13. Has watery eyes.	☐ Yes	☐ No
14. Complains of tired eyes; rubs eyes often.	☐ Yes	☐ No
15. Moves the head forward or backward while looking at distant objects.	☐ Yes	☐ No
16. Turns the head to use one eye only (closes or covers one eye).	☐ Yes	☐ No
17. Tilts the head to use one side often or all the time.	☐ Yes	☐ No
18. Places an object close to the eyes to look at it.	☐ Yes	☐ No
19. Squints while looking at objects.	☐ Yes	☐ No
20. Blinks more than you do.	☐ Yes	☐ No
21. Has difficulty walking or running; trips over objects more often than others do.	☐ Yes	☐ No
22. Is unable to see distant objects.	☐ Yes	☐ No
23. Has a family history of lazy eye or vision problems.	☐ Yes	☐ No
A "yes" answer for three or more items on 13 through 23 indicates the need for discussion and follow-up.		

Parents as Teachers.

Functional vision (optional)

Who administered the screening? (select one):
☐ Parent educator ☐ Supervisor ☐ Contracted screener ☐ Health care provider

Date completed: _____

	Left eye (select one):	**Right eye** (select one):
Blink reflex	☐ Present ☐ Absent	☐ Present ☐ Absent
Pupillary response	☐ Present ☐ Absent	☐ Present ☐ Absent
Corneal light reflex	☐ Present ☐ Absent	☐ Present ☐ Absent
Tracking	☐ Present ☐ Absent	☐ Present ☐ Absent
Reaching	☐ Present ☐ Absent	☐ Present ☐ Absent

Comments/suggestions:

Other screenings (such as acuity screening for children over 2.5 years of age: _____

Date Vision Review completed: _____