

Founders Parkway Vision Therapy  
 Dr. Joseph J. Raffa, Optometrist  
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### Teacher's Observation Checklist

I authorize the release of this information to Founders Parkway Vision Therapy / Dr. Joseph J. Raffa, O.D.

\_\_\_\_\_  
 Parent's Signature Date

The parents of \_\_\_\_\_ have granted us permission to request the following information from you, which may be associated with vision and / or visual, perceptual, or attention difficulties. All information you provide will be held in strict confidence. Please circle the number following each item, which most closely represents your observations. Thank you for your assistance!

Do you feel that s/he is having academic problems in any of these areas?	None					Many					Comments
Reading _____	1	2	3	4	5	1	2	3	4	5	
Spelling _____	1	2	3	4	5	1	2	3	4	5	
Math _____	1	2	3	4	5	1	2	3	4	5	
Handwriting _____	1	2	3	4	5	1	2	3	4	5	
Science _____	1	2	3	4	5	1	2	3	4	5	
Language / Phonics _____	1	2	3	4	5	1	2	3	4	5	
	No					Yes					Comments
Is this student's behavior a problem? _____	1	2	3	4	5	1	2	3	4	5	
Is their potential for improvement in behavior? _____	1	2	3	4	5	1	2	3	4	5	

Please rate each of the following behaviors in terms of frequency of occurrence:

	Never					Always					Comments
Short attention span during reading _____	1	2	3	4	5	1	2	3	4	5	
Short attention span during verbal or listening activities _____	1	2	3	4	5	1	2	3	4	5	
Difficulty in shifting attention to a new task _____	1	2	3	4	5	1	2	3	4	5	
Occasional lapses of attention _____	1	2	3	4	5	1	2	3	4	5	
Squirring, fidgeting, hyperactivity _____	1	2	3	4	5	1	2	3	4	5	
Reads slowly compared to class norms _____	1	2	3	4	5	1	2	3	4	5	
Substitutes words when reading _____	1	2	3	4	5	1	2	3	4	5	
Poor reading comprehension when reading silently _____	1	2	3	4	5	1	2	3	4	5	
Reads well orally, but without understanding _____	1	2	3	4	5	1	2	3	4	5	
Inadequate sight vocabulary _____	1	2	3	4	5	1	2	3	4	5	
Confuses letters or words _____	1	2	3	4	5	1	2	3	4	5	
Reverses letters or words _____	1	2	3	4	5	1	2	3	4	5	
Skips or rereads words or sentences _____	1	2	3	4	5	1	2	3	4	5	
Confuses right and left _____	1	2	3	4	5	1	2	3	4	5	
Covers or closes one eye to read _____	1	2	3	4	5	1	2	3	4	5	
Tends to hold reading material close and / or leans over desk to write _____	1	2	3	4	5	1	2	3	4	5	
Uses finger for marker when reading _____	1	2	3	4	5	1	2	3	4	5	
Complains of blurred vision in the distance _____	1	2	3	4	5	1	2	3	4	5	
Complains of blurred vision when reading or writing _____	1	2	3	4	5	1	2	3	4	5	
Complains of double vision _____	1	2	3	4	5	1	2	3	4	5	
Complains of eye discomfort or headaches _____	1	2	3	4	5	1	2	3	4	5	
Handwriting drifts uphill or downhill _____	1	2	3	4	5	1	2	3	4	5	
Size of handwriting varies greatly _____	1	2	3	4	5	1	2	3	4	5	
Tends to avoid near work _____	1	2	3	4	5	1	2	3	4	5	
Slowness or many errors when copying from the board _____	1	2	3	4	5	1	2	3	4	5	
Problems with eye-hand coordination _____	1	2	3	4	5	1	2	3	4	5	
General body coordination problems and / or toe walking _____	1	2	3	4	5	1	2	3	4	5	
Tires easily _____	1	2	3	4	5	1	2	3	4	5	
Aggressive _____	1	2	3	4	5	1	2	3	4	5	
Withdrawn _____	1	2	3	4	5	1	2	3	4	5	

Thank you for assisting us in providing optimal visual care for this student. Is there a phone number or e-mail where we could reach you for further questions or concerns? \_\_\_\_\_

Teacher's Signature: \_\_\_\_\_ School \_\_\_\_\_