1-1-1993

Pacific University College of Optometry visual screening procedures guide 1992-1993

Jay Youngman
Pacific University

Kent Wise
Pacific University

Lori Zimmer
Pacific University

Recommended Citation
https://commons.pacificu.edu/opt/387

This Thesis is brought to you for free and open access by the Theses, Dissertations and Capstone Projects at CommonKnowledge. It has been accepted for inclusion in College of Optometry by an authorized administrator of CommonKnowledge. For more information, please contact CommonKnowledge@pacificu.edu.
Abstract
The purpose of the following thesis is to promote a better understanding of Pacific University's Vision Screening Program by optometry students and the children we screen. One video and the instruction manual is for optometry student use. These both explain the procedures and guidelines for participating in the vision screening program. It is our hope that students who read the manual and watch the video prior to attending their first screening will feel more comfortable with the procedures, thereby creating a better learning experience. The second video is primarily for the young students who are recipients of vision screenings through Pacific University's Vision Screening Program. By viewing this video prior to the screening date children should feel more comfortable with the testing process, thereby decreasing the amount of patients who are unwilling to participate.

Degree Type
Thesis

Rights
Terms of use for work posted in CommonKnowledge.
Copyright and terms of use

If you have downloaded this document directly from the web or from CommonKnowledge, see the “Rights” section on the previous page for the terms of use.

If you have received this document through an interlibrary loan/document delivery service, the following terms of use apply:

Copyright in this work is held by the author(s). You may download or print any portion of this document for personal use only, or for any use that is allowed by fair use (Title 17, §107 U.S.C.). Except for personal or fair use, you or your borrowing library may not reproduce, remix, republish, post, transmit, or distribute this document, or any portion thereof, without the permission of the copyright owner. [Note: If this document is licensed under a Creative Commons license (see “Rights” on the previous page) which allows broader usage rights, your use is governed by the terms of that license.]

Inquiries regarding further use of these materials should be addressed to: CommonKnowledge Rights, Pacific University Library, 2043 College Way, Forest Grove, OR 97116, (503) 352-7209. Email inquiries may be directed to: copyright@pacificu.edu

This thesis is available at CommonKnowledge: https://commons.pacificu.edu/opt/387
PACIFIC UNIVERSITY
COLLEGE OF OPTOMETRY
VISUAL SCREENING
PROCEDURES GUIDE
1992-1993

AUTHORS
JAY YOUNGMAN
KENT WISE
LORI ZIMMER
ABSTRACT

The purpose of the following thesis is to promote a better understanding of Pacific University's Vision Screening Program by optometry students and the children we screen. One video and the instruction manual is for optometry student use. These both explain the procedures and guidelines for participating in the vision screening program. It is our hope that students who read the manual and watch the video prior to attending their first screening will feel more comfortable with the procedures, thereby creating a better learning experience.

The second video is primarily for the young students who are recipients of vision screenings through Pacific University's Vision Screening Program. By viewing this video prior to the screening date children should feel more comfortable with the testing process, thereby decreasing the amount of patients who are unwilling to participate.
INTRODUCTION

The goal of this manual is to increase the intern confidence, efficiency and speed of performance during testing procedures involved in the Pacific University Visual Screening Program for youths ranging from approximately 4 to 10 years of age.

The following paragraphs encompass what may be called a visual screenings survival kit which contains the minimal tests performed at each of the elementary screenings. We say minimal because the assigned staff O.D. may have the interns perform variations of the tests on specific or all patients.

In order to improve testing efficiency and to save time, the tests to be done are generally separated into six stations with interns deciding amongst themselves where each is going to be assigned. As the screening progresses, the interns usually exchange stations to practice other skills and to increase exposure to new experiences. These six stations are as follows:

STATION 1: CASE HISTORY

STATION 2: DISTANCE TESTS
   a. VA's
   b. Cover Test
   c. Plus Lens Test

STATION 3: NEAR TESTS
   a. VA's
   b. Cover Test
   c. NPC
   d. Bead Skills or Eye Movements
      1. Pursuits
      2. Rotations
      3. Saccades
   e. Physiological Diplopia
   f. Stereo Tests
   g. Color Tests

STATION 4: OPHTHALMOSCOPY

STATION 5: RETINOSCOPY

STATION 6: EXAM DATA EVALUATION BY STAFF O.D.

Many tests within the stations have criterion which must be met in order for a patient to pass that particular test. Any failed portions of the screening will be evaluated by the staff O.D. at station six. Be sure to take note of the pass/fail criterion where applicable in the following station descriptions.

STATION 1: CASE HISTORY
A case history entails a number of questions directed both to the patient and to the parent who may be present. Try to elicit most of your history by directly addressing the child. The history is used to discover the patient’s symptoms as well as to evaluate the patient’s medical and family history as it may relate to any current problems or predisposition to having a given problem. For example, a question to the patient’s parent may be, "Is there anyone in the family with color blindness?" If a history of color blindness is noted by the intern on the exam form at the case history station, then when the child reaches the color testing portion of the screening, the intern working at that station will know to pay very close attention to the color testing.

Case history is the most important station of the screening and it is also one of the easiest. It consists of basic information including patient name, parent name, address, phone number, date of birth, and grade. The intern must also inquire about previous trauma or surgery, any medications, prescription (Rx) worn by patient or parents, and any visually related signs or symptoms the child may have (ie. lazy eye, eye turn, eye pain).

Some common questions asked of the patient include the following:
1. Where do you sit in the classroom - in the front or the back?
2. Do you ever have trouble seeing the blackboard?
3. Do your eyes ever hurt? When?
4. Do your eyes hurt after reading?
5. Are you a good reader?
6. Do you ever get headaches? When? Where does it hurt? How do you make the headaches go away?

Record all significant history clearly and remember that you are dealing with children so try to avoid using optometric terms that neither they nor their parents will understand.

STATION 2: DISTANCE TESTS

A. Visual Acuities

VA's establish the patient's current acuity before any further testing is done and the results are compared with the retinoscopy and near VA findings during the evaluation by the staff O.D. at station six.

Introduce yourself to the child and have her/him stand with toes placed on the taped line. Show the child the occluder and tell them you are going to use it to tell how well they can see with one eye covered. While you are talking to the child, demonstrate what you are about to do on yourself.

For younger children it often works better to have someone at the chart during the testing who is pointing at each figure as the child calls out the figures. Use
pictures for young children who do not know their letters. Watch out for younger kids who tell you that they know their letters, because usually they get lower lines with picture charts.

Start testing with the larger lines to help the child understand what they are to do and, with picture charts, to understand what each of the pictures look like. Children will try their hardest to peak around the occluder when they reach the smaller figures so be sure to keep a watchful eye on them. You may need to remind them that you want to see how well they can see while only using one eye if it seems they are frequently attempting to look around the occluder. VA's are taken OD, OS, and OU through the child's current Rx with the worst eye first to reduce chart familiarity. Record the lowest line called and check whether that acuity line meets the screening pass/fail criterion. Failing (CRITERION NOT MET) on distance VA's is 20/30 or worse in either eye.

This is the most common station where the "UTT's" (unable to test) make themselves known. Some of the younger children are very scared of the situation and there is nothing you, their teachers, or parents can do that will make them get anywhere near you. If you have a child you are unable to test, try the best you can and if still no results can be obtained, record "UTT" in the space where the test result would have gone.

Be careful, however, not to mistake a shy patient for a "UTT" patient. If you have a patient who is not panicking, then you still have a chance at getting results. Be patient and let the child get used to you and often they will accept the situation enough that you may continue with testing. If the child is shy and the parent is present, it often helps immensely to have the parent hold the child on their lap and demonstrate the procedure on the parent. It may even be necessary for the parent to hold the occluder and for the child to whisper the answer into the parent's ear and then the parent tell you.

Parents accompanying their children on a screening usually sit off to the side during the VA tests. The screens that we use on the screenings are designed so that the farther off to the side a person is, the less clear the letters appear to be. If you observe a parent squinting to read the charts, you might want to have the parent look at the chart from straight on to reassure them that they can see it.

Finally, some kids are wilder or more inquisitive than others so remember that you are the boss and you have to keep control at all times. It is okay to answer a few questions, but if a line is forming at the station, tell the child it is time to do some more and go on to the next patient.

B. Cover Tests

Cover tests are done to discover any tropia or phoria which may be present or latent. Tests are done in the order of unilateral, alternating, and unilateral once again and all are done through the patient's current Rx and at the same distance at which the VA's are taken.
Start off by saying to the child that this is a very easy test and all they have to do is look at the target while you watch their eyes. The target usually used for the younger children is a stuffed animal which is danced around by an intern standing at the chart. An isolated letter is used for older children. Again, demonstrate the movement of the occluder in front of your own eyes while instructing the child.

While performing the unilateral tests, remember that it is the eye not covered by the occluder that is to be observed for signs of tropia. Conversely, it is the eye that is coming from behind the occluder that is observed for phoria while performing the alternating test. Do not forget to redo the unilateral test to uncover a latent tropia which can occur due to fatigue of the system.

When performing the cover tests, you will need to check for a subjective response of target movement. As the occluder is moved, the target often moves in a certain direction characteristic of the present phoria or tropia. If the patient reports movement of the target with the direction of movement of the occluder, this indicates an exo deviation of the eye, or an outward turning of the eye. Movement of the target in the opposite direction of the occluder motion indicates an eso deviation, or inward turning of the eye, and target motion up or down indicates the presence of a vertical deviation. Record the tropia or phoria, if found, and where needed, specify OD or OS as well as ortho (no phoria or tropia), eso, exo, and/or hyper (eye turns up) or hypo (eye turns down). In general, a quantitative amount (expressed in prism diopters or PD) of the tropia/phoria is not required on the recording sheet unless it appears to be a large amount. If needed, use a prism bar to neutralize the eye movement or apparent bead movement and record the amount of prism. A reminder: neutralize eso with BO prism; exo with BI prism; hypo with BU prism; and hyper with BD prism.

The criterion for failing the distance cover test is any tropia, 5 PD or more of eso or exo, and 2PD of vertical.

C. Plus Lens Test

The plus lens test is used to uncover latent hyperopia. Latent hyperopia occurs when the presence of hyperopia is masked by the patient's accommodative or focusing system. The plus lenses relax the accommodative system thus uncovering the latent hyperopia. This test is very quick and done binocularly. Show the child the lenses you are going to use and place them in front of your own eyes to demonstrate while telling them you are going to place the glasses in front of their eyes to see how well they can see through them. Have the child look at the lowest line which they called out during the VA test and place before their eyes a pair of +1.50D or +2.00D lenses. Ask them if they can still see the figures and if so, have them call them out. If the child can still see the letters or figures then they fail and the criterion is not met. You will see why they fail if you put the lenses in front of your own eyes and you discover that things should become very blurry.
As easy as this test is to do, it often must be redone upon request of the staff O.D. because its results may disagree with the retinoscopy findings. This happens because some children memorize the chart, look around the lenses, or just happen to guess correctly and thus give a false test result. Watch for this and if a patient gets all the figures correct, ask them to call out a different line and watch their eyes carefully.

If parents are present, they may be concerned that all of a sudden their child cannot see well. Reassure them that they should not be able to see as well with these particular glasses and let the parents look through the lenses themselves.

Remember to watch your patient's eyes. Try to memorize the chart early in the screening so that you can concentrate on your patient. Children will want to sneak a peek around occluders and lenses because they want to see better irregardless of what you want them to do. Some of them are extremely sneaky when it comes to peeking and will wait until you turn your head or look away to do so. Therefore, whatever you can do to decrease the amount of time you must spend looking elsewhere will most likely help in the efficiency of testing.

**Station 3: Near Tests**

This station involves the testing of near visual acuities, near cover testing, near point of convergence (NPC), eye movements, stereo testing or depth perception, and color testing on all boys and any girls when indicated.

**A. Near Visual Acuities**

The instruction set is the same as for distance VA's except this test is done at 40 cm or 16 inches. It is important to keep the child at this distance to get the most accurate results. It is also very important to be sure the near lighting (usually a table lamp) illuminates the target evenly and that there are no shadows on the target. Again test the worst eye first to reduce chart familiarity, followed by the other eye and finally both eyes. The occluder may be held by you or the child but if the child holds it, be sure he/she does not peek around it. As with distance VA's, use the Snellen chart for children who know their alphabet and use the picture chart with those who do not. It is important to start with the larger symbols so the children can get familiar with the pictures used on the charts. Let the children call the pictures what they want for their interpretation of the pictures may vary. However different their description may be, it is never wrong as long as they are consistent throughout the test. Failing criteria is 20/30 or worse in either eye. The same hints as for distant VA's are often very helpful in successful near VA testing.

**B. Near Cover Test**
The instruction set is the same as for far cover testing except the near target will be a bead, preferably with a small letter or picture on it. Finger puppets or stuffed animals are a great help with very young patients or children with poor attention spans. It is often necessary to continually remind the child to keep looking at the target. As with far cover testing, show the occluder movement and what you will be doing on yourself first so the child will know what to expect. The fail criterion is any trope, eso of 5 PD or more, exo of 10 PD or more, and any vertical phoria of 2 PD or more. Remember, if you see movement which looks significant, neutralize it with a prism bar. As with far cover testing, check for a subjective response of target movement.

C. Near Point of Convergence (NPC)

This is a test of the eyes ability to fixate a target and converge as it is brought closer while maintaining singleness. The point where the target breaks into two is the patient's NPC. You want to note the subjective response (when the child reports two targets) as well as the objective NPC. The child's eyes will converge and at the NPC, one or both of the child's eyes will swing outward thus breaking fusion of the target and causing it to double. The subjective and objective points are usually at the same point or within an inch or two of each other. The point of doubling as you move the target in is the "break." The "recovery" also needs to be recorded. To determine this, have the child close his/her eyes, move the bead inside the break point, and have him/her open their eyes. Tell the child that when he/she opens their eyes they will see two targets. Move the target slowly away from the child telling them to concentrate and look at the bead and tell you when it again becomes one. Once more, note subjective and objective responses. The recovery is usually a little farther out from the nose than the break. Record the break and recovery distances in either inches or centimeters. If the child could maintain singularity until the bead touched the nose, record "TN" for "to nose." Also watch the smoothness of convergence as this may give you a clue as to eye movement abilities.

It is helpful to do the test on yourself first to show the child how your eyes cross. There is no defined pass/fail criteria although a break before 4-6 inches should be suspect. Any break or recovery that seems suspicious should be brought to the attention of the supervising O.D. for further evaluation.

D. Bead Skills

These tests evaluate the gross ability of the eyes to perform pursuit movements (tracking), saccadic movements (which are important in reading), and rotational movements. In all cases, pay close attention to whether movements are smooth or jerky, accurate, and if there is a midline jump. The midline jump is a developmental characteristic physiologically present in decreasing amounts to the ages of 6 or 7 years. If present in older children, it can signify a developmental problem. Again, demonstrate all these test on yourself first.

1. Pursuits
Pursuits are the movements involved while following or tracking an object at slow speeds. Use one bead as the target (a puppet or stuffed animal may be necessary with young children), and have the child follow it with ONLY the eyes. It may be necessary to hold or have the child's parent hold the child's head still. Move the bead at a constant, slow speed, horizontally, vertically, and in both oblique directions (45 and 135 degrees) from the center of fixation. You want to check eye movements up to about a 30 degree range from the center of fixation. Record if the movements are smooth and accurate (S & A), jerky and not accurate (record as such), and mentally note if there is or is not a midline jump. If a jump is present, record for further evaluation by the staff O.D. One last element to evaluate is whether or not the patient suffers any pain in any direction of gaze. Ask for this as you move the bead and record if present.

2. Saccades

These are the eye movements essential for reading. They are also the movements responsible for quick changes of fixation (looking from point to point). An indication of poor saccadic skills is often found in the case history when it is reported that the child has poor reading abilities. For this test, use two beads or targets of different colors or appearance. Have the patient look with only the eyes at the one which you call and it may be necessary to again hold the head still. Test horizontally, vertically, and obliquely but only up to about 30 degrees because with saccades of greater than this amount a head turn usually occurs first. Watch the smoothness (is it one smooth saccade or a series of small saccades) and watch for undershooting or overshooting. Undershooting is when the saccade falls short of the bead and another small saccade is necessary to reach the bead. Overshooting is just the opposite. The saccade goes past the target and a small saccade back to the target is necessary for fixation. By 7-8 years of age, a child should be to adult levels of saccadic movements but before that point, an over/undershoot of up to 20 percent is not abnormal. Past ages of 7-8, only a one to two percent error is acceptable. If a child cannot saccade without head turning, note this and bring it to the attention of the staff O.D. Head movement is a developmental part of eye movements up to about the third or fourth grades at which point it should be gone. Also note any midline jump and record if present past the afore mentioned ages.

3. Rotations

Rotations test pursuit abilities during rotation of the eyes (circular movements of the eyes). Test with only one target (a bead or stuffed animal/puppet) and move the target slowly in a clockwise and then a counterclockwise direction. Check for pain during the movements and watch for smoothness, accuracy, and fullness of movement. Record as "S, A, and F" if all movements seem normal or describe movements if not normal. Abnormal or jerkiness may only be in one small area of rotation so watch closely during the entire 360 degrees of rotation. With younger patients it is not uncommon to see saccadic motions which yield a more hexagonal appearance to the rotation. This should be gone by ages 5-6 and by age seven the rotations should be smooth, accurate, and full with no midline jump.
E. Physiological Diplopia

Physiological diplopia is a normal and expected phenomena which is caused by identical image points falling on different retinal points. Use two beads of different colors as the targets. Hold one bead about ten to fifteen centimeters from the patient's nose (outside their NPC but not too far) and the other bead about one meter away from the nose. Have the child look at the near bead and tell you how many far beads they see and then have them look at the far bead and ask how many near beads they see. In both cases the answer should be two. Record positive or negative physiological diplopia. A negative result could indicate suppression and should be brought to the attention of the staff O.D.

F. Stereo Tests

Stereo tests are used to determine the presence of third degree fusion or depth perception. The different stereo tests have differing stereo acuity demands. Stereo acuity is the ability of the patient to detect changes in angular difference between objects in space, or in other words, the ability of the patient to tell if two targets differ in their location in space (i.e. one being closer than the other).

1. Stereo Fly

This is only a gross test and basically determines if depth perception is present in the patient. The child wears a pair of Polaroid glasses. Hold the stereo fly and have the child slowly reach out and pinch the fly's wings. The child should pinch a little above the actual plane of the page because the fly should appear to float off the page. The stereo fly only tests to 2000 arc seconds so is easily seen to float and thus is not a definitive test. Believe it or not, a few children will be scared of the fly because it is a big bug so use the stereo reindeer, if one is available, or go on to the stereo animals. The stereo fly booklet will contain the stereo animals as well as the Wirt four circle test. If there is not a four circle test, there will be a three ball test which works the same as the four circle test.

2. Stereo animal

The stereo animal contains three rows of animals and each row tests a different stereo acuity. In each row, only one of the animals appears to float. Have the child put on the Polaroid glasses and point at the animal that floats off the page. Sometimes it may be helpful to play like the animals are in cages at the zoo and one animal has gotten out of its cage and you want the child to push it back in before it escapes. The top row of animals tests 400 arc seconds, the second row 200, and the bottom 100 arc seconds. These are still fairly gross tests but do demand much greater acuities.

3. Wirt 4 Circle Test
This is the finest stereo test we normally use on a screening. The circles test from 800 to 40 arc seconds. Again, have the patient wear the Polaroid glasses and point to or push the floating circle back in the page.

G. Color Testing

This is an important screening test and necessary for all boys and any girls indicated. It is primarily a genetic defect that affects boys and is often picked up during the case history so be sure and check there first. The test commonly used on the screenings is the pseudo-isochromatic plates. These are arranged in a small book and the plates contain either numbers or a twisting line of various colors. Each plate tests for different color deficiencies so be sure and do as many as possible to cover all areas of color vision.

The test requires good lighting so you will want to use a table lamp. The test is performed monocularly, commonly using an eye patch as an occluder. Tell the children you want to play pirate with them and they will usually accept the patch easily. With children who do know their numbers use the number plates. Have the patient tell you what number they see on the page as you flip through the book. For those children who do not know their numbers, the twisting lines work well. Give the child a bead and have them trace the line they see. You can play like the bead is them and they are walking on a sidewalk and if they fall off they will fall into secret ooze or mud or whatever sounds gross.

Record as normal color vision or if the child seems to not be able to detect a color well, note the color for further evaluation by the staff O.D. The plates often do not seem to work well so use whatever objects are available (i.e. pencils, pens, beads, bottle caps, parts of the stuffed animals, etc.) to test different colors especially the blues, green, yellows, and reds.

Station 4: Ophthalmoscopy

Ophthalmoscopy is done to evaluate the ocular health of the eye and adnexa. During the course of the screening, the cup, disc, vasculature, fundus, and foveal light reflex are observed. The intern must look for any pathologies or anomalies of the fundus.

Begin setting up for the procedure by having the child stand on a chair or table so that you are in a comfortable position to examine his/her eye. Tell the child that you are going to be shining a light in their eye but that they should not look at it. Instead give them a target (stuffed animal) to look at in the distance. Also, explain that you will be very close to the child and you may possibly touch them. Throughout the procedure keep telling the child to look at the target. The key to ophthalmoscopy with children is to reassure them as much as possible and be quick!!

Record any abnormalities or check with the staff O.D. if you are unsure of what you have seen. The patient passes if nothing unusual is observed.
Station 5: Retinoscopy

Retinoscopy is done to evaluate the refractive status of the patient. The amount of myopia or hyperopia, astigmatia, and anisometropia will be recorded.

To begin the procedure greet the child and explain to them that they are going to watch a cartoon with you. Try to make the child as comfortable as possible before entering the darkened area. The child should sit on a table top or counter with his/her current Rx in place. Place the +1.50D or +2.00D glasses over the top of the Rx so that the working distance does not need to be considered. Neutralize each meridian separately with the lens bar and record on the screening form.

While you are neutralizing each eye make sure the child keeps his/her attention on the cartoon so accommodation will be fully relaxed. One way to encourage this is to ask the child to tell you what is happening in the cartoon. Also, make sure you are quick because the younger children have short attention spans.

The passing criteria for retinoscopy is less than +1.50D of hyperopia, less than -.75D of myopia, less than ±1.00D of astigmatism, and less than ±1.00D of anisometropia. Remember, these amounts are taken over their Rx and indicate a need for a new Rx or a first Rx as in the case of an emmetropic child.

Station 6: Staff O.D. Evaluation

Station 6 is where the staff O.D. evaluates the overall status of the patient's visual system. All tests have been completed and results recorded and this allows for a final evaluation. The staff O.D. will look at all the findings, instruct the repetition of any needed tests, and make necessary recommendations or referrals to the patient. The staff O.D. will also further evaluate any abnormal or questionable results found during the screening.

For those who have not yet been to a screening and are not familiar with some of the tests listed above, do not let anxiety keep you from participating. At a minimum, you can perform stations one and two without difficulty and you will be surprised how quickly you will learn the tasks at the other stations.

In summary, we have only mentioned a few tips that we have found beneficial in helping things go smoother and quicker. These have included:

1. Speak in plain, concise, layman terms on the child's level.
2. Demonstrate all possible procedures on yourself or the parent first.
4. If a child will not cooperate, go on to the next test or patient - time is important.
5. With younger children use pictures and stuffed animals as the test targets and get the parent or teacher involved if necessary.
6. Last but not least - BE QUICK!!!!
The key thing to remember is that these are children you are dealing with so use whatever tricks you can think of to help you get the results you need.

We highly recommend that you take part in the screening program early in your academic career because from participation in only one of the visual screenings, the first and second year student's experiences and skills will improve greatly and will put her/him at a great advantage in the class room as well as any following screenings.

It is your school and it is your tuition dollars that give you the right to participate in screenings and build your skills and experience so why not take advantage of it. Have fun and good luck!!!!!!!
Student Evaluation

1. Do you feel that the video explained the screening process in an organized fashion?

2. Did you understand what was being tested at each station?

3. Name one thing you found helpful about this video?

4. After watching this video do you feel you would be less apprehensive about attending a vision screening? If so, why or why not?

5. Have you ever attended any of the vision screenings in the past? If so, what did you think of the experience?

6. For those of you who have participated in a screening, do you feel watching this video would have helped you prior to attending? Why or why not?

7. Any comments or suggestion:

Thank you for your participation.
School Official's Evaluation

1. Do you feel that the video explained the screening process in an organized fashion that was easy for the children to understand?

__________________________________________________________________________

2. Did you understand what was being tested at each station? Did the children?

__________________________________________________________________________

3. Name one thing you found helpful about this video?

__________________________________________________________________________

4. If there is any area you would change, please explain what that area is and why.

__________________________________________________________________________

6. After watching this video do you feel the children would be less apprehensive about attending a vision screening? If so, why or why not?

__________________________________________________________________________

7. Has your school participated in a vision screening program in the past? If so, what did you think of the program?

__________________________________________________________________________
8. For those of you who have participated in a vision screening, do you feel watching this video would have helped your students feel more at ease during the screening process? Why or why not?

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

9. Any comments or suggestion:

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Thank you for your participation.