# PARENT/CAREGIVER INTERVIEW

**For Students who are Blind or Visually Impaired**

Student Name: _____ Date: _____
Parent/Caregiver Name: _____
Parent e-mail:_____ Parent Cell Phone:_____

**Medical Information**

What is your understanding of your child's visual impairment? _____

_____

_____

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**

If your child has been prescribed glasses, does your child wear them?_____

_____

If your child has been prescribed low vision devices, does he use them?_____

_____

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 is the smallest object you've seen your child try to pick up? _____
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? Yes ____No_____How close? _____
What kind of things does your child appear not to see, or have difficulty seeing? _____

_____

What does your child say or do that tells you he's 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, 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?_____

**Response to Lighting**

What kind of lighting is best for your child?_____
Is your child sensitive to bright lights? _____
Does glare from shiny surfaces bother your child?_____

**During Activities Of Daily Living**

How does your child use his vision during mealtimes?_____

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

**During Social Interactions**

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

_____

**During Play & Leisure**

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 do they enjoy reading/looking at?_____

_____

**Mobility & Travel**

Does your child ever have problems getting around in the dark? ..... Yes ___ No____

If so, explain: _____

Does your child have problems with bright light? ..... Yes ___ No____

If so, explain: _____

How does your child adjust to different lighting? _____

_____

Does your child have trouble getting around in unfamiliar environments? ..... Yes ___ No____

If so, explain: _____

Does your child have trouble traveling independently outdoors? ..... Yes ___ No____

How does your child use his vision to move through the home? _____

_____

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

_____

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

_____

**Additional Notes**

_____

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