PARENT INTERVIEW
(Academic Students K-12)

Student Name:

Parent (s) Interviewed:

Date:

Setting:

Vision/Medical History (TVI conduct a review of the records)
Has your child had an ophthalmological exam? Yes No
When?

Who was the doctor (telephone and address)?

What caused your child's impairment?

Is the eye condition stable or progressive?

Has your child had an audiological exam? Yes No
When?

Who was the audiologist?

Does your child have other documented disabilities?

Where could we access additional medical records if they are needed?

What medications does your child take and when are they administered?

In the past, has your child had a medical plan available at school?

Does your child have any medical restrictions?

Does he/she seizure? Yes No
How often?

Does anything in the environment (e.g. light, noise, etc.) seem to trigger seizure activity?

Adapted from Dr. Dixie Mercer – Texas School
for the Blind and Visually Impaired, 1998
by Heartland AEA 11Vision Department-2003

Educational Progress (TVI conduct a review of the records)

What was the last school that served your child?

Who was the teacher?

Was attendance an issue? Yes No

How are your child's listening skills?

Does your child follow directions?

What educational materials does your child have the most difficulty with at school?

What subject area do they have the most difficulty in at school?

Does your child have difficulty completing homework? Yes No
If yes, explain why you think this is so:

How does your child complete their homework?

Are you pleased with your child's educational progress? Yes No
Explain:

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
Explain:

How do they adjust to different lighting?

Does your child have trouble getting around in unfamiliar environments? Yes No
Explain:

Does your child travel independently outdoors? Yes No
Explain:

What sports does your child engage in for recreational purposes?

Visual Response

Does your child watch television? Yes No

How far away from the screen does your child sit?

Does your child like to play computer or video games? Yes No

How far away from the screen does your child sit?

Does your child like to play with books or read? Yes No

What size pictures and font do they enjoy reading?

Does the glare on a page seem to bother your child?

If your child has been diagnosed as being totally blind, do you think that he or she sees? Yes No

Explain:

Do you notice your child bringing things closer to look at them? Yes No

How close does your child generally hold small objects?

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

Do you ever notice your child turning their head to look at objects? Yes No

If "yes," which way do they turn their head?

Do you feel that there are areas of your daughter/son's visual field, which is more effective than other areas?

Explain:

Does your child experience visual fatigue?

How long can your child read before experiencing visual fatigue?

Are there places where you would like the examiner to observe?

Gym___ Auditorium___ Lunch room___ Cafeteria___

Music room___ Hallways___ Playground___ Stairs___ Classroom___

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Activities of Daily Living
Is your child able to perform activities of daily living at a level equal to other children their age? Yes No
If "no," what activities give him/her the most trouble?

Personal body care___ Self-help___ Social habits___ Home assistance___

Recreation/leisure skills___ Moving in the near environment___

Social
Does your child have friends? Yes No

Does your child interact with other children in about the same way as other children their age? Yes No
Explain:

Personality
Are there activities that your child particularly enjoys?

Are there activities that your child avoids?

What sort of foods does your child like to eat?

What things does your child like to listen to?

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