

**SCHOOL VISION EVALUATION**  
**Report Form**

**A School Vision Evaluation is required** for all children **within six months prior to entering** Nebraska schools for the first time (*includes beginner grades including Kindergarteners, transfers, and other students new to Nebraska*) [Nebraska Revised Statute 79-214]

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

School: \_\_\_\_\_ Date: \_\_\_\_\_

Student Status (*check one*):  Beginner Grade  Transfer Student from Out of State

<b>REQUIRED TESTS*</b>	Pass	Fail	Recommend Further Evaluation <small>(comments noted below)</small>
Amblyopia	_____	_____	_____
Strabismus	_____	_____	_____
Internal Eye Health	_____	_____	_____
External Eye Health	_____	_____	_____
Visual Acuity			
Right eye @ distance (20 ft.):		20/____	aided/unaided
Left eye @ distance (20 ft.):		20/____	aided/unaided
Right eye @ near (16 in.):		20/____	aided/unaided
Left eye @ near (16 in.):		20/____	aided/unaided

\*A vision evaluation consisting of these required tests meets the legal requirements for the State of Nebraska but is not a complete eye examination such as most eye doctors perform.

<b>ADDITIONAL TESTS</b>	Pass	Fail	Recommend Further Evaluation	Did Not Test
Eye Alignment at Distance	_____	_____	_____	_____
Eye Alignment at Near	_____	_____	_____	_____
Depth Perception	_____	_____	_____	_____
Color Vision	_____	_____	_____	_____
Focusing Amount	_____	_____	_____	_____
Focusing Flexibility	_____	_____	_____	_____
Focusing Lag (Accuracy)	_____	_____	_____	_____
Convergence (Crossing) Ability	_____	_____	_____	_____
Saccade (Rapid) Eye Movement	_____	_____	_____	_____
Pursuit (Tracking) Eye Movement	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____

**COMMENTS/RECOMMENDATIONS:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Evaluation performed by:** \_\_\_\_\_  O.D.  M.D.  P.A.  A.P.R.N.  
 (signature)

**Office Phone Number:** ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ **Date:** \_\_\_\_\_