

## 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

REQUIRED TESTS*	Pass	Fail	Recommend Further Evaluation <i>(comments noted below)</i>
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.*

ADDITIONAL TESTS	Pass	Fail	Recommend Further Evaluation
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:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
*(signature)*

O.D.     M.D.     P.A.     A.P.R.N.