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 *(comments noted below)*
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	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:** _____