

SCHOOL VISION EVALUATION REPORT FORM
Please return this form to your child's school health office.

Nebraska Revised Statute 79-214 requires a visual evaluation by a physician, physician assistant, advanced practice registered nurse, or an optometrist within six months prior to the *entrance of a child into kindergarten or beginner grade or, in the case of a transfer from out of state, to any other grade of the local school.* The examination will consist of testing for amblyopia, strabismus, and internal and external eye health, with testing sufficient to determine visual acuity. No such visual examination will be required of any child whose parent or guardian objects to this testing in writing.

| | | | |
|---|----------------|-----------------------------|--|
| Name _____ | | Date of Birth _____ | |
| School: _____ | | Date of Exam _____ | |
| Student Status (check one) Beginner Student _____ | | Out of State Transfer _____ | |
| Required Tests: | Pass | Fail | Recommend Further Examination (See Comments Below) |
| Amblyopia | _____ | _____ | _____ |
| Strabismus | _____ | _____ | _____ |
| Internal Eye Health | _____ | _____ | _____ |
| External Eye Health | _____ | _____ | _____ |
| Visual Acuity | | | |
| 20 feet | Right 20/_____ | Left 20/_____ | with / without glasses |
| 16 inches | Right 20/_____ | Left 20/_____ | with / without glasses |
| COMMENTS/RECOMMENDATIONS: | | | |
| _____ | | | |
| _____ | | | |
| Evaluation Performed by: _____ | | Date: _____ | |
| ___ O.D. ___ M.D. ___ P.A. ___ A.P.R.N. | | | |

WAIVER OF VISUAL EXAMINATION

Date _____

I do not wish to obtain a visual examination for my child _____
Child's Name

 Signature of Parent/Guardian