Report of Visual Evaluation

PARENT/GUARDIAN: This form is provided as a convenience to you and your child's health care provider in meeting the requirement for visual evaluation in Nebraska schools. No specific form is required by the statute. The information provided here may be shared with school personnel as needed to promote your child's safety and educational success.

Student Name	School	Grade
Zip	Date of Birth	Sex: ☐ M ☐ F

Physician Name

PART I: Provider By signing below, the qualified medical examiner (as stated above) certifies that the student specified received a visual evaluation as required by Nebraska Revised Statute 79-214 for entry into school at the beginner grade (Kindergarten or 1st grade), or out-of-state transfer to any grade.

Visual Evaluation Report	PASS	FAIL	Recommend Further Evaluation
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:

Signature of Examiner	Date of Exam

Name/Title of Examiner (please print or use stamp)

Examiner Address or Clinic Stamp:

PART II: Parent/Guardian: As parent/guardian of the student named above, I consent for the release of this information to:

_____
Name of School

_____ _____
Parent/guardian signature Date

_____
Printed name and relationship to student