

EXAMINATION SHEET

Date _____

Serial No. _____

Project Name _____

 Project Theme See to Earn See to Learn See to be Safe

1. Registration

Camp Location Name	Village/Area	District
Unique ID	First Name	Last Name
Father's/Husband's Name	Phone No.	
Currently wears eyeglasses <input type="checkbox"/> Y <input type="checkbox"/> N	Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other	Age _____ Year of Birth
Dept/Grade/Vehicle type – HCV/MCV/LCV		Desig/Role/Route

- | | | |
|-------------------|---|--|
| Occupation | <input type="checkbox"/> Tailor, Garments, Textile, Artisans, Weaver, Cobbler | <input type="checkbox"/> Farmer, Fisherman, Animal Husbandry, Other Agriculture |
| | <input type="checkbox"/> Carpenter, Mason, Technician, Plumber | <input type="checkbox"/> Shopkeeper, Retail worker, Parlors, Barber, Waiter |
| | <input type="checkbox"/> Driver – Truck, Bus, Taxi, Passenger vehicle | <input type="checkbox"/> Cleaner, Domestic Worker, Cook, Guard, Laborer |
| | <input type="checkbox"/> Mechanic, Conductor, Electrician, Loader, Transport-Helper | <input type="checkbox"/> Govt Representative/Worker, Manager, Administrator, Clerk, Other Office Job |
| | <input type="checkbox"/> Doctors, Nurse, Pharmacist, Health worker | <input type="checkbox"/> Unemployed |
| | <input type="checkbox"/> Teacher, Administrator, Trainer, Counsellor | <input type="checkbox"/> Others (Specify) |
| | <input type="checkbox"/> Student | |
| | <input type="checkbox"/> Housewife | |
| | <input type="checkbox"/> Senior citizen/Retired | |

2. Eye Examination

A. Presentations/Complaints <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center;">RE</th> <th style="text-align: center;">LE</th> </tr> </thead> <tbody> <tr><td>Headache /Eye Strain</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Blurred Vision</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Pain/Redness</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Watering /Discharge</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Swelling</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Squint</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> </tbody> </table>		RE	LE	Headache /Eye Strain	<input type="checkbox"/>	<input type="checkbox"/>	Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	Pain/Redness	<input type="checkbox"/>	<input type="checkbox"/>	Watering /Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Swelling	<input type="checkbox"/>	<input type="checkbox"/>	Squint	<input type="checkbox"/>	<input type="checkbox"/>	B. Visual Acuity <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center;">RE</th> <th style="text-align: center;">LE</th> </tr> </thead> <tbody> <tr><td>Distance Vision</td><td></td><td></td></tr> <tr><td style="text-align: center;">Unaided</td><td></td><td></td></tr> <tr><td style="text-align: center;">With Glasses</td><td></td><td></td></tr> <tr><td>Near Vision</td><td></td><td></td></tr> </tbody> </table> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td rowspan="4" style="vertical-align: middle; text-align: center;">D. Drivers Only</td> <td>Contrast Sensitivity _____ %</td> </tr> <tr> <td>Diplopia <input type="checkbox"/> Y <input type="checkbox"/> N</td> </tr> <tr> <td>Night Vision Loss <input type="checkbox"/> N <input type="checkbox"/> Mild <input type="checkbox"/> Severe</td> </tr> <tr> <td>Visual acuity of 6/18 or better in both eyes <input type="checkbox"/> N <input type="checkbox"/> Y</td> </tr> </table>		RE	LE	Distance Vision			Unaided			With Glasses			Near Vision			D. Drivers Only	Contrast Sensitivity _____ %	Diplopia <input type="checkbox"/> Y <input type="checkbox"/> N	Night Vision Loss <input type="checkbox"/> N <input type="checkbox"/> Mild <input type="checkbox"/> Severe	Visual acuity of 6/18 or better in both eyes <input type="checkbox"/> N <input type="checkbox"/> Y	C. Diagnosis <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td><input type="checkbox"/> Presbyopia</td></tr> <tr><td><input type="checkbox"/> Myopia</td></tr> <tr><td><input type="checkbox"/> Hyperopia</td></tr> <tr><td><input type="checkbox"/> Astigmatism</td></tr> <tr><td><input type="checkbox"/> Normal</td></tr> <tr><td>Color blindness</td></tr> <tr><td><input type="checkbox"/> No</td></tr> <tr><td><input type="checkbox"/> R-G <input type="checkbox"/> B-Y</td></tr> <tr><td><input type="checkbox"/> Complete</td></tr> </table>	<input type="checkbox"/> Presbyopia	<input type="checkbox"/> Myopia	<input type="checkbox"/> Hyperopia	<input type="checkbox"/> Astigmatism	<input type="checkbox"/> Normal	Color blindness	<input type="checkbox"/> No	<input type="checkbox"/> R-G <input type="checkbox"/> B-Y	<input type="checkbox"/> Complete
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<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Suspected Cataract <input type="checkbox"/> Infection <input type="checkbox"/> Other _____																																																				
Hospital <input type="checkbox"/> Gov't <input type="checkbox"/> Charitable <input type="checkbox"/> Private Name _____ VS partner: <input type="checkbox"/> Y <input type="checkbox"/> N																																																				

3. Eyeglasses Prescription

Right Eye				Left Eye			
SPH	CYL	AXIS	VISION	SPH	CYL	AXIS	VISION
ADD				ADD			

First Time Wearer: <input type="checkbox"/> Y <input type="checkbox"/> N	Frame Model No
Current Glasses: <input type="checkbox"/> Needs new power <input type="checkbox"/> Accurate	Frame Color
Lens Type: <input type="checkbox"/> Bifocal <input type="checkbox"/> Single-Near <input type="checkbox"/> Single-Distant	IPD
Glasses Booked: <input type="checkbox"/> Rx <input type="checkbox"/> Readers Dispensed: <input type="checkbox"/> Readers <input type="checkbox"/> Pre-cut	Segment Height

Sign _____	Optometrist _____	Salesperson _____	Customer _____
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Customer copy – tear here

Serial No.	Unique ID	Name
Camp Location Name	Phone No	
Booking Date	Delivery Date	Amount Paid
Eyeglass Type: <input type="checkbox"/> Rx <input type="checkbox"/> Reading		

CONSENT FORM

Please tick all applicable options:

- Data Usage:** I, the undersigned, hereby give my consent to VisionSpring to collect my personal and eye-screening information for providing eyeglasses and for research, data analysis, and insight generation at a collated level.
- Referral:** I, the undersigned, hereby give my consent to VisionSpring to share my personal and eye-screening information with eye hospitals/eye care organizations for considering me for further diagnosis and/or treatment of cataract and/or other complex eye diseases. VisionSpring bears no responsibility for such diagnosis and/or treatment, and the decision to undergo the same is my sole responsibility and an act of my free will.
- Photography and videography:** I, the undersigned, hereby irrevocably grant to VisionSpring and its affiliates and their successors, assigns and licensees the unrestricted right (but not the obligation) to: (a) use my name, image and likeness in connection with the Media in any manner, in whole or in part, severally or in conjunction with other works, in any media now or hereinafter known, throughout the universe, in perpetuity, for any lawful purpose whatsoever, including, without limitation, for promotion, advertisement and trade; and (b) edit, change, or alter the Media without restriction. I do not expect, and I will not be paid, any money for the rights granted hereunder. I hereby waive any right to inspect or approve any use of the Media.

I hereby release and waive, and agree not to bring at any time in the future, any claims or demands against VisionSpring or its affiliates or their successors, assigns or licensees, arising out of or relating to their use of the Media, including, without limitation, assertions of (1) rights of publicity (including any allegedly improper or unauthorized use of my name, likeness or image); (2) rights of privacy; (3) presenting me in a false light (including any allegedly false or misleading portrayal of me); (4) copyright, trademark or other intellectual property infringement; (5) defamation, libel or slander; (6) breach of alleged moral rights; or (7) any other claimed violation of a personal or property right

- I, the undersigned, hereby represent and warrant that I am at least 18 years old, of sound mind, and have the legal right and authority to give my consent for myself or on behalf of the children I represent as Principal/ Teacher/ Parent/ Guardian (Please select one). I also hereby agree to provide my valid Government identity proof.

Further, I have gone through the rights and implication of the above-mentioned points and have no objection on the same.

- I am suffering from eye problem and have myself visited outreach program. I have been informed about COVID precautions.**

Temperature °F ($\leq 100^\circ$)

- Cough & shortness of breath Fever & chill Sore throat New onset-loss of taste/smell
 Contact with COVID + Eye redness/conjunctivitis Headache/muscle pain

Agreed and accepted:

Name:

Signature:

Entry allowed

Yes

No