VisionSpring
See well. Do well.

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 ☐ **Y** ☐ **N** **Gender** ☐ **M** ☐ **F** ☐ **Other** **Age** Year of Birth

Dept/Grade/Vehicle type – HCV /MCV/LCV | Desig/Role./Route Both

Occupation

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

2. Eye Examination

A. Presentations/Complaints

	RE	LE
Headache /Eye Strain	☐	☐
Blurred Vision	☐	☐
Pain/Redness	☐	☐
Watering /Discharge	☐	☐
Swelling	☐	☐
Squint	☐	☐

B. Visual Acuity

Distance Vision	RE	LE
Unaided		
With Glasses		
Near Vision		

C. Diagnosis

- ☐ **Presbyopia**
- ☐ **Myopia**
- ☐ **Hyperopia**
- ☐ **Astigmatism**
- ☐ **Normal**

D. Drivers Only

Contrast Sensitivity ____________________ %

Diplopia ☐ Y ☐ N

Night Vision Loss ☐ N ☐ Mild ☐ Severe

Visual acuity of 6/18 or better in both eyes ☐ N ☐ Y

Color blindness
☐ No
☐ R-G ☐ B-Y
☐ Complete

E. Referred for further diagnosis and examination:

☐ Y ☐ N ☐ Suspected Cataract ☐ Infection ☐ Other_____________________________

Hospital ☐ Gov't ☐ Charitable ☐ Private Name ________________________________ VS partner: ☐ Y ☐ N

3. Eyeglasses Prescription

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

First Time Wearer: ☐ **Y** ☐ **N**

Current Glasses: ☐ **Needs new power** ☐ **Accurate**

Lens Type: ☐ **Bifocal** ☐ **Single-Near** ☐ **Single-Distant**

Glasses Booked: ☐ **Rx** ☐ **Readers** **Dispensed:** ☐ **Readers** ☐ **Pre-cut**

Frame Model No	
Frame Color	
IPD	
Segment Height	

Sign	Optometrist	Salesperson	Customer

Customer copy – tear here

Serial No. | Unique ID | Name

Camp Location Name | Phone No

Booking Date | Delivery Date | Amount Paid

Eyeglass Type: ☐ **Rx** ☐ **Reading**

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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 responsibilityand 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 (≤100°)

☐ 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