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. ___________________________

□ Y □ N Gender □ M □ F □ Other Age ___________________________ Year of Birth ___________________________

Dept/Grade/Vehicle type – HCV/MCV/LCV ___________________________ Design/Role/Route ___________________________

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

2. Eye Examination

A. Presentations/Complaints

<table>
<thead>
<tr>
<th>Complaint</th>
<th>RE</th>
<th>LE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headache /Eye Strain</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Blurred Vision</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Pain/Redness</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Watering/Discharge</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Swelling</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Squint</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

B. Visual Acuity

- Distance Vision
  - Unaided
  - With Glasses

- Near Vision

C. Diagnosis

☐ Presbyopia
☐ Myopia
☐ Hyperopia
☐ Astigmatism
☐ Normal

D. Drivers Only

- Contrast Sensitivity ___________________________ %

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

- Night Vision Loss □ N □ Mild □ Severe

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

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

<table>
<thead>
<tr>
<th>Right Eye</th>
<th>Left Eye</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPH</td>
<td>SPH</td>
</tr>
<tr>
<td>CYL</td>
<td>CYL</td>
</tr>
<tr>
<td>AXIS</td>
<td>AXIS</td>
</tr>
<tr>
<td>VISION</td>
<td>VISION</td>
</tr>
</tbody>
</table>

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

Optometrist ___________________________ Salesperson ___________________________

Customer ___________________________

Customer copy – tear here

Serial No. ___________________________ Name ___________________________
Camp Location Name ___________________________ Unique ID ___________________________
Phone No. ___________________________
Booking Date ___________________________ Delivery Date ___________________________
Amount Paid ___________________________

Eyeeglass Type: ☐ Rx ☐ 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 (≤100°F)

☐ 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