***If this is for a student, the school nurse or health coordinator should complete the information in this box.***

**Student ID: Student Name: DOB:** / / **School: Grade: Date of Eye Exam**: / /

**Appointment Time**:  **Location:**

**OneSight Vision Clinic Consent Form**

Based on a specific set of criteria, you or your child were referred to a OneSight vision clinic to receive a free eye exam and (if needed) eyeglasses.

**Please note**: If you are the parent or guardian of the referred individual, please complete this form with their personal information to attend the vision clinic.

**The OneSight Vision Clinic will take place on the date and location set forth at the top of this page.** The free vision services will be provided in conjunction with OneSight, a leading vision care nonprofit, which provides a comprehensive eye exam and stylish glasses (if needed).

Please read the following information carefully and, if you decide to participate (or allow your child to participate) in the OneSight Vision Clinic, please complete and return the attached Consent Form to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Note that if you/your child participates in the OneSight Vision Clinic, the expected time at the vision clinic will be approximately 1-3 hours. Please make arrangements for you/your child to have any necessary medications and/or food available on their assigned clinic day. You/your child will receive a copy of your vision exam results at the clinic.

If you have any questions about the information provided in this Consent Form, please contact  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Thank you!**

***DID YOU KNOW?***

***80% of what children learn is visually processed, yet one in four students in the U.S. has an undiagnosed vision problem affecting his or her ability to see and learn in school. An eye exam and glasses (if needed) can help students achieve better learning through better vision.***

***\* Please keep this page for your records so you know the date, time, and location of your/your child’s appointment.***



***Patient/Parent/Guardian MUST Complete All Sections of This Form and Sign Below for Participation in the OneSight Vision Clinic***

I, (and, if child) parent/guardian of

***Print Name (Parent / Guardian if Child)******Print Student’s Name***

give my permission for me/my child to receive a free eye exam and glasses, if needed, at the OneSight Vision Clinic at the time, date, and location provided on the previous page.

**I. Waiver of Dilated Fundus Exam**

#### The state board of optometry may require a dilated fundus exam as part of an eye examination performed by a licensed optometrist. A dilated fundus exam is a thorough exam of the peripheral retina aided by the use of topical dilating eye drops. This procedure is used to diagnose abnormalities of the retina such as detachments, tears, tumors, infections, hemorrhages and genetic abnormalities. The dilating drops will leave the pupils dilated for approximately four hours. During this period the patient may experience blurry vision and light sensitivity, which may make reading difﬁcult.

***I DO***

***I DO NOT***

***√-* CHECK BOX** give my permission for the optometrist to perform a dilated fundus exam during the examination process at OneSight Vision Clinic

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**II. Permission to Photograph**

In the course of providing vision services at the OneSight Vision Clinic, OneSight may wish to take photographs of me/my child, video and/or audio recordings of me/my child, and/or statements made or written by me/my child (the “Materials”) for marketing or public relations purposes related to the OneSight Vision Clinic and its partners. I understand that by indicating my permission below, I waive the right to approve the finished copy of any electronic or printed Materials that are produced. I acknowledge that I am not entitled to compensation of any kind as a result of the use of the Materials. I further release OneSight from all liability that arises out of the use and disclosure of the Materials.

***I DO***

***I DO NOT***

***√-* CHECK BOX**give my permission to OneSight to use, publish, disclose and reproduce the Materials, without restriction as to manner, frequency, or duration of use and understand that my decision will not affect whether I/my child receive(s) an eye exam or glasses at the OneSight Vision Clinic. I have the right to revoke this permission at any time by notifying OneSight in writing at the following address: OneSight, Attn: Chief Financial Officer, 4000 Luxottica Place, Mason, OH 45040.

**III. Confidentiality/Privacy and Impact Reporting**

#### If I am signing this as the parent or guardian of a child, I understand that in order to provide vision services, OneSight will have access to the child’s confidential health care records that are maintained by OneSight, to help facilitate the services. I understand OneSight at all times maintains the confidentiality of the information it receives and agrees to never disclose my/my child’s confidential information to any third party or government agency for any purpose without my consent or as otherwise required by law. I also understand that OneSight collects the vision screening and eye exam data of all patients seen at the clinic. I understand that the data used by OneSight will not identify me/my child and that OneSight performs data analysis so it may share general impact reporting about improvements in patients’/students’ vision after participating in the OneSight Vision Clinic.

**IV. Release of Liability**

#### In exchange for the free vision services provided to me/my child at the OneSight Vision Clinic, I release and discharge from any and all claims, demands, and liability arising out of the services provided at the OneSight Vision Clinic or any use granted herein, the officers, directors, employees, agents, affiliates, and/or assigns of the following organizations and individuals: School or District personnel; the independent optometrist(s) who perform the eye exam; any co-sponsoring agency, and OneSight.

# SIGN HERE

***PATIENT/PARENT/GUARDIAN SIGNATURE DATE***

**IMPORTANT! PLEASE FILL IN**

***YOU / YOUR CHILD’S HEALTH HISTORY***

**Patient Information & Health History**

*In order to help facilitate the eye exam the patient, parent, or guardian must complete this brief health history to receive vision services.*

## Do you/your child or any immediate family member (parents, grandparents, and siblings) have any of the following:

Diabetes: Yes, Who: No

Glaucoma: Yes, Who: No

High Blood Pressure: Yes, Who: No

Do you/your child have any known allergies? Yes, please list: No

Are you/your child currently taking any medication? Yes, please list: No

Do you/your child currently wear glasses? Yes No

Have you/your child ever worn glasses? Yes No

#### When is the last time you/your child had an eye exam?

#### Please list any known problems or symptoms you/your child has in regards to his/her vision and/or eye health:

#### Please list any recent or major surgeries you/your child has had: