ONESIGHT/WALKING SHIELD ADULT FORM

NAME: _____

AGE: _____

DOB: _____

Adult ID#: _____

1-A. Waiver of Dilated Fundus Exam-see *below for details*

CHECK BOX ☐ I DO / ☐ DO NOT - give my permission for the optometrist to perform a dilated fundus exam during the examination process at the OneSight Vision Clinic.

1-B. Permission to Photograph Student-see *below for details*

CHECK BOX ☐ I DO / ☐ DO NOT - give my permission to be filmed or photographed and understand that my decision will not affect whether I receive an eye exam or glasses at this Clinic.

Release of Liability *I release and discharge from any and all claims, demands and liability arising out of this event or any use granted herein the officers, directors, employees, agents, affiliates, and/or assigns of the following groups: District personnel; the independent optometrist(s) who perform the eye exam; any co-sponsoring agency; OneSight, and Luxottica Group, S.p.A.*

SIGN HERE _____ _____

SIGNATURE DATE

Explanation Section 1-A -Dilated Fundus Exam

The state board of optometry may require a dilated fund us 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.

Explanation Section 1-B -Permission to Photograph

This event may be photographed or filmed for use in communications and/or news media coverage relating to the OneSight Vision Clinic and its partners.

IMPORTANT! ADULT PLEASE FILL IN

ADULT HEALTH HISTORY

Adult Information & Health History

In order to help facilitate the eye exam, *the receipient must complete this brief health history :*

Does any immediate family member (parent, grandparents, and sibling) have any of the following:

Diabetes:	YES Who: _____	☐ NO
Glaucoma:	☐ YES Who: _____	☐ NO
High Blood Pressure:	☐ YES Who: _____	☐ NO
Do you have any known allergies?	☐ YES Please list _____	☐ NO
Are you currently taking any medication?	☐ YES Please list _____	☐ NO
Do you currently wear glasses?	☐ YES ☐ NO	
Have you ever worn glasses?	☐ YES ☐ NO	

Please list any known problems or symptoms you have had in regards to your vision and/or eye health:

_____

_____

_____

_____