PARENTAL CONSENT FORM FOR ONESIGHT℠

DATE:	**October 6, 2015**
TO:	**PARENTS/GUARDIANS OF ELIGIBLE CHILDREN NEEDING EYE EXAMS**
FROM:	**COMMUNITY SERVICE CENTER VISION COORDINATOR**
RE:	**PARENTAL CONSENT FOR ONESIGHT FOLLOW UP EYECARE**

DATE OF EXAMINATION:	**APPOINTMENT TIME:**
November 2nd, 3rd, 4th, or 5th , 2015	**Middle School and High School Students: 8 AM – 9 AM**
Location: National City Camacho Gym, Las Palmas Park, 1810 E. 22nd Street National City, CA 91950	

OneSight, a Luxottica Group Foundation and a non-profit 501(c)(3) corporation in the U.S., is a family of charitable programs dedicated to improving vision for those in need worldwide through outreach, research and education. OneSight's outreach programs include the hand-delivery of vision care and eyewear to those in need. OneSight has provided free vision care and eyewear to millions of adults and children in need over the last 20 years and will soon be here to help bring the gift of clear vision to children in your community.

Both the examination and eyewear will be donated by OneSight.

If your child needs eyewear based on the results of the eye examination provided by a licensed optometrist, a trained professional will assist your child in selecting a pair of glasses that are suitable for his/her prescription, face shape, features and coloring.*

The entire process, from registration at the stated appointment time to the completion of the eye exam and eyewear, will take 2-4 hours. Please make arrangements to ensure that your child will have available any necessary medications and/or food that will be needed during this time period. Due to space limitations, parents cannot always accompany the child during a Clinic.

If you want your child to participate in this program please complete the attached parental consent form with the requested information and sign the form. **Failure to return this form with the appropriate signatures will result in forfeiture of your child's appointment.**

**** Due to the charitable nature of this program, no breakage protection warranty will be provided on the glasses. Glasses that are lost, stolen or broken will not be replaced.***

Health History:
In order to help facilitate the eye exam please complete this brief health history for the child named above. This information must be returned with the attached parental consent form.

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

DIABETES	Yes	Whom: ____________________________________	No
GLAUCOMA	Yes	Whom: ____________________________________	No
HIGH BLOOD PRESSURE	Yes	Whom: ____________________________________	No

Does your child have any known ALLERGIES? Yes, please list: __________________________ No

Is your child currently taking any MEDICATION? Yes, please list: __________________________ No

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

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I,__________________________________ parent/guardian of, ____
(Print Parent's/Guardian's Name) (Print Child's Name)

give my permission for my son/daughter to receive a free eye exam and eyewear, if needed, on the above date and time at the OneSight Clinic at the above location.

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. Reading may be difficult during this time period.

I do ☐ do not ☐ give my permission for the optometrist to perform a dilated fundus exam during the examination process at the OneSight Clinic.

Permission to Photograph Child:
This event may be photographed or filmed for use in internal communications and for advertising, promotion and publicity relating to OneSight and its sponsors throughout the world.

I do ☐ do not ☐ give my permission for my child to be filmed or photographed and understand that my decision will not affect whether my child receives 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: the independent optometrist(s) who perform the eye exam; any cosponsoring agency; OneSight, and Luxottica Group, S.p.A.

______________________________________ __________________________
(Parent/Guardian Signature) (Date)

By signing below, acknowledgement is given of receipt of OneSight's **Notice of Privacy Practices**.

____ ____________________________
(Parent/Guardian Signature) (Date)

FAILURE TO RETURN THIS FORM WITH THE APPROPRIATE SIGNATURES IN TWO AREAS WILL RESULT IN FORFEITURE OF YOUR CHILD'S APPOINTMENT.

If you have any question, please contact: Katie Filzenger at (619) 787-2783
Please return this permission slip to: School Nurse no later than October 19, 2015