FLORIDA HEIKEN
Children's Vision Program
FOUNDED 1992

FREE EYE EXAM AND GLASSES - SCHOOL PROGRAM

Dear Parent/Guardian,

The Florida Heiken Children's Vision Program is offering comprehensive eye exams and glasses if necessary, for Florida public school students in your county who qualify to participate. This program is available at no cost to you or your child's school.

If your child is able to participate after verification, we will send you a form through your child's school with the name, address and phone number to a participating doctor, for you to call and schedule an appointment. The doctor will also receive the same form to have your child's information on file. When there are 15 or more eligible students in one school, we may schedule our mobile vision bus to visit your child's school to perform the eye exams.

The comprehensive eye exam, administered by an eye doctor, includes a thorough examination of your child's vision and eye health. In order to perform the examination, the use of eye drops to dilate the pupils is used, which allows the doctor to get the most accurate eye health information and prescription for eye glasses, should they benefit your child. The drops are safe to use, and adverse reactions are extremely rare. Light sensitivity and blurry near vision are normal for up to 4-6 hours following the exam.

For your child to participate in this FREE program, please fill out the attached form completely, sign at the bottom and have your child return the form to the school nurse or counselor.

Remember: As 85% of what a child perceives, comprehends, and remembers depends on the visual system. It is imperative that all children have the gift of good vision for success in school and their future. Last year, about 80% of those who were examined needed glasses. Your child may need glasses!

If you have any questions please contact your child's school counselor or the Heiken main office at (305) 856-9830 or 1-888-996-9847.

601 Southwest 8th Avenue, Miami, FL 33130
Phone: (305)856-9830/ 1(888)996-9847 Fax: (305)856-9840/ 1(888)980-8474
www.miamilighthouse.org/floridaheikenprogram.asp

Free Exam & Eyeglasses School Program

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For School Personnel Use Only:
County: _____
Mandatory Two Vision Screening Fail Dates: Fail Date #1 _____ Fail Date #2_____
(Fail Dates Must Be Within Same School Year)
Is the Student on the Free or Reduced Lunch Program? Circle One: YES NO
Signature:_____ Date:_____

School (full name)_____ Grade_____ Teacher _____

Student's name_____ M / F Student's DOB _____

Address _____ City _____ Zip code _____

Home phone _____ Parent's day phone _____

Parent/Guardian name _____Email address_____

Ethnicity (Circle One): African American Asian Hispanic Native American White (non-Hispanic) other

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Does your child wear glasses? Yes _____ No _____ Broken _____ Lost _____

Has your child seen an eye doctor in the past year? Yes _____ No _____

Please list any eye problems your child has: _____

_____

Please list any health problems your child has:_____

_____

Please list any medication or eye drops your child uses: _____

_____

Please list any seasonal or medication allergies your child has: _____

Does your child have any special needs/developmental delays? Yes _____ No _____

Does your child require any auxiliary aids (such as interpreter, sign language, visual aids, Braille) Yes _____ No_____

If Yes or Other, Please explain_____

Has your **child** had any of the following:

YES	NO	
☐	☐	Eye surgery / Injury
☐	☐	Eye turn / Strabismus / Lazy eye
☐	☐	Vision therapy / Eye patching
☐	☐	Glaucoma
☐	☐	Diabetes
☐	☐	Sickle cell
☐	☐	Asthma
☐	☐	Headaches
☐	☐	Other

Has anyone in your child's **family** had any of the following:

YES	NO	
☐	☐	Eye turn / Strabismus / Lazy eye
☐	☐	Blindness
☐	☐	Macular Degeneration
☐	☐	Glaucoma
☐	☐	High Blood Pressure
☐	☐	Diabetes
☐	☐	Sickle cell
☐	☐	Other

Please explain any "YES" answers from above:_____

Consent for eye examination –By signing below, I authorize my child to have a full eye examination including dilation, which allows the doctor to conduct a complete eye health exam.

Notice of privacy practices –By signing below, I understand that the Notice of Privacy Practices for the Florida Heiken Children's Vision Program is available for review if I should request a copy via phone at (305)856-9830/ 1(888)996-9847.

Mutual exchange of information – By signing below, I authorize the mutual release of information between the Florida Heiken Children's Vision Program and your County Public Schools to release any and all optometry medical reports on my child to participating program providers.

Claims - If your child is covered under an insurance plan, we may inform you and send you a list of local doctors who accept your plan.

*I/We release and hold harmless the County School Board of any and all responsibility and liability for any injury or claim resulting from participation in the Florida Heiken Children's Vision Program because of accident or mishap involving the participation of my child/ward in the program.

Does your child have health insurance: Y/N Company:_____ **Does your child have vision coverage: Y/N**

Is the Student on the Free or Reduced Lunch Program? Circle One: YES NO

PARENT/GUARDIAN SIGNATURE_____ **Date:**_____

The Florida Heiken Children's Vision Program is an equal opportunity organization and does not discriminate against otherwise qualified applicants on the basis of race, color, religion, ancestry, age, sex, marital status, national origin, disability or veteran status.

Revised 6-14-2012.

School Contact: Please fax completed form with Heiken Fax Cover Sheet to (305)856-9840 / 1(888)980-8474