FLORIDA HEIKEN CHILDREN'S VISION PROGRAM

Statewide Vision Program
601 Southwest 8th Avenue
Miami, FL 33130
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www.miamilighthouse.org/floridaheikenprogram.asp

EXAM RESULTS

(PLEASE FAX REPORT TO # ABOVE)

School _____ Grade _____ Teacher_____

Student _____ File# _____ Exam Date _____

Dear Parent/Guardian,

The following are your child's eye exam results. The examining physician's recommendations are below, as well as a copy of the glasses prescription. Please keep this for your records.

VISUAL ACUITY

Without glasses
Right Eye: 20 / _____
Left Eye: 20 / _____

With glasses
Right Eye: 20 / _____
Left Eye: 20 / _____

RESULTS

□ No further care or eyeglasses are indicated at this time. A yearly eye examination is recommended.

□ Prescription glasses would benefit your child. They will be delivered to the optometrist in approximately 3 weeks. A copy of the glasses prescription is written below.

□ Referral to other medical specialist is indicated for the following reason: (This is not covered by the Florida Heiken Program)

_____
_____
_____

*Was a Dilated Eye Examination Performed as Required by the State of Florida: **Circle: YES NO**
*If NO Please Explain Reason:*_____

GLASSES PRESCRIPTION

OD_____

OS_____

ADD_____ Use for_____

Doctor Signature _____ Date _____

Doctor Name / License No. _____