

FOR COUNSELOR USE ONLY

Eligibility Criteria: (Please check ALL that apply)

- Student does not have insurance
- Does not receive Medicaid
- Is on free/reduced meal
- Unable to access eye care

**MIAMI LIGHTHOUSE
HEIKEN CHILDREN'S VISION PROGRAM
CONSENT FORM
(Please use pen only)**

The **Miami Lighthouse Heiken Children's Vision Program** is offering comprehensive vision exams and prescription eyeglasses, if necessary, for your child at **no cost** to you or to the school. The only requirement is that your child does not have Medicaid or insurance to pay for this examination, and qualifies for free/reduced price meals in school.

Your child has been identified (through vision screening failure or teacher request) as in need of vision-care services. If you want your child to see the Optometrist and receive eyeglasses, if necessary, please **answer the following questions, sign the authorization form, and return it to your child's school.**

I, the parent of _____, certify that I have read and understand this consent form, and that I
(Child's Name)
meet the eligibility criteria explained in the previous paragraph.

I authorize the **Miami Lighthouse Heiken Children's Vision Program** to provide my child with a comprehensive eye examination and prescription eyeglasses, if necessary, at no cost to me or to the school. *Eyeglasses will be provided on site approximately two weeks after the eye exam.*

ALL of the following information must be completed:

Parent/Guardian Name (print) _____

Parent/Guardian Signature _____

Child's Name _____ Date of Birth _____ Grade _____

School Name _____ Teacher's Name _____

Child's Address _____ City _____ Zip _____

Home Phone # _____ Parent/Guardian Work # _____

Gender (Please circle): Male Female

Ethnicity (Please circle): African American, Hispanic, Haitian, White (non-Hispanic), Asian or Pacific Islander.

- If you have any questions, please contact the school's counselor or Carmen Arguijo, our program coordinator, at the Miami Lighthouse Children's Vision Program (305) 856-9830 or Fax (305) 856-9840.

Part of this examination includes the use of eye drops to dilate the pupils. A dilated exam allows the doctor to get the most accurate eye health information and eyeglass prescription. The eye drops are safe to use and severe adverse reactions are extremely rare. Light sensitivity and blurry near vision are normal following the exam.

Please sign here if you agree to your child receiving a complete eye exam including dilation _____

Please sign here if you refuse the dilation _____

INSTANT VISION PROGRAM CASE HISTORY

1. HAS YOUR CHILD EVER COMPLAINED ABOUT (check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Headache, Nausea, Dizziness | <input type="checkbox"/> Burning or Itchy Eyes |
| <input type="checkbox"/> Rubbing Eyes | <input type="checkbox"/> Blinking frequently |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Seeing "Spots" | <input type="checkbox"/> Eye Strain/Tired Eyes |
| <input type="checkbox"/> Other (please explain) _____ | |

2. ARE YOUR CHILD'S EYES (check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Crossed (in or out) | <input type="checkbox"/> Watering |
| <input type="checkbox"/> Encrusted | <input type="checkbox"/> Red/Irritated |
| <input type="checkbox"/> Mucous/Discharge | <input type="checkbox"/> Sensitive to light |
| <input type="checkbox"/> Other (please explain) _____ | |

3. DOES YOUR CHILD (check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Complain, "I can't see" | <input type="checkbox"/> Lose place reading |
| <input type="checkbox"/> Shift head to use one eye | <input type="checkbox"/> Sit too close to TV |
| <input type="checkbox"/> Write letters backward | <input type="checkbox"/> Rub his/her eyes |
| <input type="checkbox"/> Have difficulty with school work | <input type="checkbox"/> Bump into objects |
| <input type="checkbox"/> Favor one eye/squint to see | <input type="checkbox"/> Avoid close work |
| <input type="checkbox"/> Confuse similar words | <input type="checkbox"/> Wear glasses |
| <input type="checkbox"/> Have discipline problems | <input type="checkbox"/> Wear contact lenses |
| <input type="checkbox"/> Seem easily distracted | <input type="checkbox"/> Leave out/confuse small words |
| <input type="checkbox"/> Other (please explain) _____ | |

4. HAS YOUR CHILD EVER EXPERIENCED THE FOLLOWING (check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Frequent bumps on the eyelid | <input type="checkbox"/> Wearing an eye patch |
| <input type="checkbox"/> Attention deficit disorder | <input type="checkbox"/> Bad falls |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Head trauma | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> High fevers | <input type="checkbox"/> Measles/Mumps |
| <input type="checkbox"/> Other (please explain) _____ | |

5. HAS YOUR CHILD EVER HAD AN EYE EXAM? Yes No When _____

6. IS YOUR CHILD TAKING ANY PRESCRIPTION MEDICATION OR OVER THE COUNTER MEDICATION INCLUDING EYE DROPS? Yes No

List _____

7. HAS YOUR CHILD EVER REPEATED A GRADE IN SCHOOL? Yes No When _____

8. FAMILY MEDICAL HISTORY (check all that apply)

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Glasses/Contacts | <input type="checkbox"/> Eye disease |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Strabismus/Crossed eyes | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Stroke |

9. WHY DO YOU THINK YOUR CHILD SHOULD HAVE A VISION EXAMINATION AT THIS TIME?

