



**Miami Lighthouse Heiken Children's Vision Program**  
**601 Southwest 8<sup>th</sup> Avenue**  
**Miami, Florida 33130**  
**Phone: (305) 856-9830**  
**Fax: (305) 856-9840**

**REQUEST FOR EYECARE APPOINTMENT**  
 (Requests cannot be processed without ALL completed information)

SCHOOL NAME \_\_\_\_\_ DATE \_\_\_\_\_

Name and position of school staff member submitting request below:

NAME: \_\_\_\_\_ POSITION: \_\_\_\_\_

PHONE#: \_\_\_\_\_ FAX#: \_\_\_\_\_

**ELIGIBILITY CRITERIA MUST BE CONFIRMED BEFORE SUBMITTING REQUEST**

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|--|--|
| <p><b>ELIGIBILITY CRITERIA:</b> (Check all that apply)</p> <p>STUDENT DOES NOT HAVE INSURANCE <input type="checkbox"/></p> <p>DOES NOT RECEIVE MEDICAID <input type="checkbox"/></p> <p>IS ON FREE/REDUCED MEAL <input type="checkbox"/></p> <p>UNABLE TO ACCESS EYE CARE <input type="checkbox"/></p> | <p><b>CHILDREN'S PROGRAM OFFICE USE ONLY</b></p> <p>PREVIOUSLY SEEN: _____ DATE: _____<br/>         DR: _____<br/>         FILE #: _____</p> <p>NEW REQUEST: _____ FILE #: _____<br/>         APPOINTMENT DAY: _____ TIME: _____<br/>         DR.: _____</p> |
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REASON FOR REQUEST (failed school screening, teacher/counselor referral, etc)/COMMENTS:

\_\_\_\_\_

\_\_\_\_\_

STUDENT: FIRST NAME \_\_\_\_\_ LAST NAME \_\_\_\_\_

DOB \_\_\_\_\_ AGE \_\_\_\_\_ GRADE \_\_\_\_\_ RACE \_\_\_\_\_ GENDER \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE (H) \_\_\_\_\_ WORK \_\_\_\_\_

PARENT/GUARDIAN NAME \_\_\_\_\_