FLORIDA HEIKEN
Children's Vision Program, LLC
FOUNDED 1992
A DIVISION OF MIAMI LIGHTHOUSE FOR THE BLIND AND VISUALLY IMPAIRED, INC.

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)
Signature:_____ Dates:_____

School _____ Grade_____ Teacher_____
Student's name_____ M / F Student's DOB_____
Address_____ City_____ Zip Code_____
Home phone_____ Parent's day phone_____
Parent/Guardian name_____
Ethnicity (Circle One): African American Asian Hispanic Native American White (non-Hispanic) Other

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Is the Student on the Free or Reduced Lunch Program? Yes_____ No_____
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.
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 will 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.

Parent 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 2/27/12