Student ID #

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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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: ____

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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 ______

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:____

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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.
Mutual exchange of information – By signing below, I authorize the mutual release of information between the Florida Heiken Children's Vision Program and 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.

Parent Signature: ____ Date: ____________________