



FAX COVER SHEET

FAX THIS FORM AND THE SIGNED PARENTAL CONSENT FORM TO 305-856-9840 / 1-888-980-8474

Date: _____

Attn: Florida Heiken Children's Vision Program Coordinator

Referring School/Camp/Agency: _____

County: _____

Contact Person: _____

Contact Person's Phone: _____ Fax: _____

Total Number of Students Referring: _____

Requesting (Choose One): _____ Voucher for in-office exam _____ Mobile Visit (30 minimum*)

Comments:

*30 minimum can be at one school or 2 schools within 5 miles of each other, please list schools in the vicinity

Important Warning: This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is **STRICTLY PROHIBITED**. If you have received this message in error, please notify the sender immediately and destroy the related message

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