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

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