2020-2021 No Cost Eye Exam & Eyeglasses School Program

FOR 6-9 WEEK FASTER PROCESSING, APPLY ON YOUR PHONE AT: WWW.FLORIDAHEIKEN.ORG

***HEIKEN PORTAL INFO* (For School/Screening Personnel Use Only):** **County:** _____ **Referring school or agency:** _____ **Teacher** _____ **Vision Screening: PASS / REFER** screening date: _____	**For Heiken Use Only:** Date Acct #: Entered: Status: Auth. Date: Ins:

Complete School Name _____ **Grade** ___ **Student I.D.** _____ **Male/Female**
Student's Name _____ **Student's Date of Birth (MM/DD/YY)** _____
Address_____ **Apt** _____ **City** _____ **Zip Code** _____
Cell Phone_____ **Parent's Day Phone** _____
Parent/Guardian Name (print) _____ **Email Address** _____
# of People in Household _____ **Annual Income $** ____ ____ ____ , ____ ____ ____ **.00 Per Year**
Ethnicity: African-American ☐ Asian ☐ Hispanic ☐ Native-American ☐ White (non-Hispanic) ☐ Haitian ☐ Other ☐
Spoken Language: English ☐ Spanish ☐ Creole ☐ Portuguese ☐ Other ☐ _____

Has your **child** had/have any of the following:

YES	NO	
☐	☐	Eye Exam in the last year
☐	☐	Wears Glasses
☐	☐	Eye Surgery/Injury or Condition
☐	☐	Vision Therapy
☐	☐	Headaches
☐	☐	Glaucoma
☐	☐	Diabetes
☐	☐	Sickle Cell
☐	☐	Asthma
☐	☐	Allergies _____
☐	☐	Any Medication or Eye Drops: _____
☐	☐	Special needs/development delays? _____

Has your child's **family** had any of the following:

YES	NO	
☐	☐	Eye Turn / Lazy Eye
☐	☐	Blindness
☐	☐	Macular Degeneration
☐	☐	Glaucoma
☐	☐	High Blood Pressure
☐	☐	Sickle Cell

COVID-19 – any family member within 2 wks

☐	☐	Fever, Cough, Sore Throat
☐	☐	Loss of smell/taste
☐	☐	Contact with anyone diagnosed with COVID-19
☐	☐	Traveled out of USA

☐ ☐ Require any auxiliary aids (such as interpreter, sign language, visual aids, wheelchair, Braille) _____

Please explain any "YES" answers from above: _____

FLORIDA HEIKEN
Children's Vision Program, LLC
A DIVISION OF MIAMI LIGHTHOUSE

Consent for eye examinations - By signing below, I authorize the Florida Heiken Children's Vision Program (FHCVP) to provide my eligible child with a comprehensive dilated eye examination, either at school site by a mobile Optometrist or the office of an assigned participating provider.

Notice of privacy practices – By signing below, I understand that the Notice of Privacy Practices for the FHCVP is available for review if I should request a copy via phone at (305)856-9830 / 1(888)996-9847, and that security cameras are in use and recording on all mobile units at all times.

Mutual exchange of information – By signing below, I authorize the mutual release of information among the FHCVP, its funders, my County Public Schools (CPS), and participating providers of any and all optometry medical reports on my child, to determine appropriate care. I also authorize my CPS to release any required information that may be missing or unclear to process this application. I understand that I may be contacted by FHCVP or its funders to provide an anonymous opinion about the services received, but I have the right to refuse to participate if contacted.

*I/We understand that COVID-19 infection can lead to illness, disability, or even death and knowingly take the risk and release and hold harmless the County School Board and FHCVP or any of its doctors or staff of any and all responsibility and liability for any injury or claim should my child, or someone he/she comes in contact with, become positive or presumptively positive diagnosed with the COVID-19 virus or because of accident or mishap involving the participation of my child/ward resulting from participation in the FHCVP.

YES ☐ NO ☐ I allow my child to be photographed by FHCVP for public relations purposes, and waive any/all present/future claims to the photos.

YES ☐ NO ☐ **Text Messages**: I consent to receive text and email messages regarding program participation. Message and data rates may apply.

SIGNATURE of LEGAL GUARDIAN (required)_____ **Date:** _____

Authorization to use insurance benefits —If my child has an insurance plan that is accepted and has an opportunity to be seen on a mobile unit visit (only), I hereby authorize Florida Heiken Children's Vision Program to use my child's insurance for a comprehensive, dilated eye exam, and eyeglasses, if prescribed (includes selected frames, clear poly lenses, and no add-ons). I understand this will use my child's insurance vision benefit.

SIGNATURE (Authorization to use insurance benefits) _____ **Date:** _____

For any questions, please call 1-888-996-9847.

School/Agency: Please fax completed form with Heiken Fax Cover Sheet to (305)856-9840 / 1(888)980-8474

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 5.20.2020