Free Exam & Eyeglasses

School Program

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)
Is the Student on the Free or Reduced Lunch Program? Circle One: YES NO
Signature:________________________ Date:____________________

School (full name)_____________________________ Grade__________ Teacher ______________________________

Student's name____ M / F Student's DOB ___________________

Address ____ City ___________________ Zip code ______________

Home phone ___________________________________ Parent's day phone _____________________________________

Parent/Guardian name ___________________________________Email address___________________________________

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: ____

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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 may 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.

Does your child have health insurance: Y/N Company:___________________ Does your child have vision coverage: Y/N

Is the Student on the Free or Reduced Lunch Program? Circle One: YES NO

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 6-14-2012.

Please fax completed form with Student's School Cover Sheet to (305)856-9840/1(888)980-8474