

# NO COST EYE EXAMS & GLASSES FOR CHILDREN

*Accessible on any internet enabled smart phone/tablet/computer  
English / Español / Kreyòl / Português*

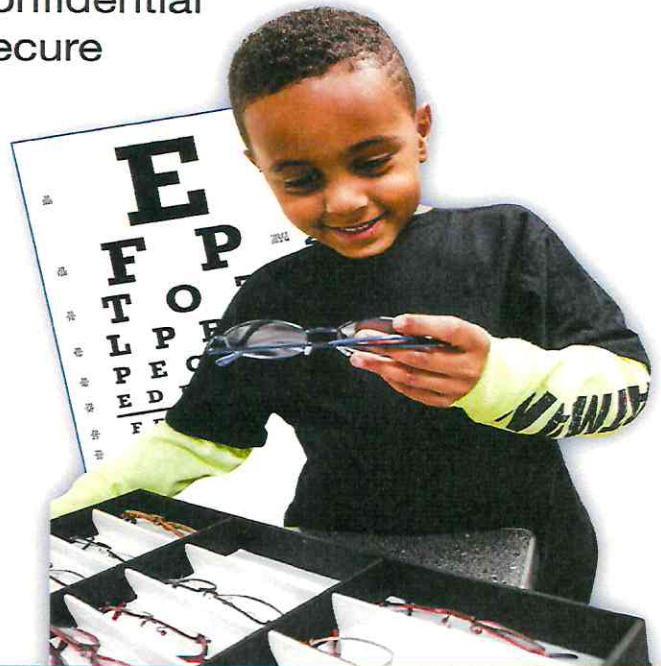
**PARENTS APPLY NOW!**  
**[www.floridaheiken.org](http://www.floridaheiken.org)**



- Florida Students
- Pre-K through 12th Grade
- Reapply Every School Year

## **USE THE HEIKEN PORTAL**

- Confidential
- Secure



All student information is kept confidential and not shared with any other entity.



Partially funded by:



# Florida Heiken Children's Vision Program Form 2021/2022 (All Grades)

## 2021-2022 No Cost Eye Exam & Eyeglasses School Program

**FOR 6-9 WEEK FASTER PROCESSING, APPLY ON YOUR PHONE AT: [WWW.FLORIDAHEIKEN.ORG](http://WWW.FLORIDAHEIKEN.ORG)**

<b>HEIKEN PORTAL INFO (For School/Screening Personnel Use Only):</b> County: _____ Teacher _____ Referring school or agency: _____ Private must list scholarship: _____ Vision Screening: PASS / REFER screening date: _____	<b>For Heiken Use Only:</b> Acct #: _____ Date Entered: _____ Status: _____ Auth. Date: _____ Ins: _____
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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? \_\_\_\_\_
- Require any auxiliary aids (such as interpreter, visual aids, wheelchair, Braille)

Please explain any "YES" answers from above: \_\_\_\_\_

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
- Child is learning virtually

**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, including the Florida Department of Health for auditing purposes, 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 4.23.2021