Florida Heiken Children's Vision Program Form 2017/2018 (All Grades)

THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA
Coordinated Student Health Services • 1400 NW 14th Court, Ft. Lauderdale, FL 33311 • (754) 321-1575

Florida Heiken Children's Vision Program
(Broward Free Eye Exam & Eyeglasses School Program)

If your child fails a vision screening and is eligible, the Florida Heiken Children's Vision Program and its health care providers may provide him/her with a **FREE**, non-invasive, dilated vision exam, and if needed, **FREE** eyeglasses. To apply to receive this **FREE** service, complete, sign and return this form to your child's school. For more information call 1-888-996-9847 or visit http://miamilighthouse.org/Florida_Heiken_Program.asp.

School (Full Name) _____ Grade_____Teacher _____ Student I.D. _____
Student's Name_____ Male/Female (Circle One) Student's Date of Birth _____
Address _____ Apt._____ City _____ Zip Code _____
Home Phone _____ Parent/Guardian Day Phone _____
Parent/Guardian Name (Print) _____ E-mail Address _____
Ethnicity (Circle One): African-American Asian Hispanic Native-American White (Non-Hispanic) Haitian Other _____
Spoken Language (Circle One): English Spanish Creole Portuguese Other _____
Has your child seen an eye doctor in the past year? Yes_____ No _____ Does your child wear glasses? Yes _____ No _____
Please list any medication or eye drops your child uses: _____
Please list any allergies your child has: _____
Does your child have any special needs/developmental delays? Yes _____ No _____ Explain: _____
Does your child require any auxiliary aids (such as interpreter, sign language, visual aids, wheelchair, Braille)? Yes _____ No _____ If Yes, please explain: _____

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

YES	NO	
☐	☐	Eye Surgery / Injury
☐	☐	Vision Therapy
☐	☐	Headaches
☐	☐	Glaucoma
☐	☐	Diabetes
☐	☐	Sickle Cell
☐	☐	Asthma

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
☐	☐	Other

Please explain any "YES" answers from above: _____

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

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/ (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 Broward County Public Schools (BCPS) of any and all optometry medical reports on my child to participating program providers, to determine appropriate care. I also authorize BCPS to release any required information on my child's eligibility for the free/reduced lunch program and any missing or unclear information requested to process this application. **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.**

LEGAL GUARDIAN SIGNATURE (to receive exam) _____ **Date:** _____

Authorization to bill insurance - 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 bill 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 bill insurance) _____ 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.

For School Personnel Use Only:
County: **Broward**
Referring school/agency: _____
Vision Screening Fail Date (Mandatory): _____
Qualifies for Free/Reduced Program (Circle One): YES NO
Signature: _____ **Date:** _____

For Heiken Use Only: Scanned ☐
Account #: _____
Eligibility Status: _____
Eligibility Date: _____
Insurance: _____

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