FLORIDA HEIKEN
Children's Vision Program, LLC

NO COST Eye Exam and Glasses for Children
www.floridaheiken.org

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

PARENTS APPLY NOW!

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

WHY USE THE HEIKEN PORTAL?

- Faster Processing
- Confidential and Secure

601 SW 8th Avenue • Miami, Florida 33130
(305) 856-9830 or 1 (888) 996-9847
www.floridaheiken.org

Heiken does NOT share student's personal information with any other agencies.

The Children's Trust · Florida Panthers Foundation · Health Foundation of south florida · Lions · Florida Health · Marlins Charity Partner

2019-2020 No Cost Eye Exam & Eyeglasses School Program

FOR FASTER, SECURE PROCESSING, APPLY ON YOUR PHONE AT: WWW.FLORIDAHEIKEN.ORG

HEIKEN PORTAL INFO (For School/Screening Personnel Use Only):	For Heiken Use Only:	Scanned ☐
County: _____ School Code: _____	Account #.: _____	**Date**
Vision Screening: **PASS / REFER** screening date: _____	Eligibility Status: _____	**Entered:**
Referring school or agency: _____	Date Eligibility Verified: _____	
Referral Agency Code (if referral is not from school): _____	Insurance: _____	_____
	Subscriber ID:	

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.

Complete School Name _____ **Grade** ___ **Teacher** _____ **Student I.D.** _____

Student's Name _____ **Male/Female** **Student's Date of Birth** _____

Address _____ **Apt** _____ **City** _____ **Zip Code** _____

Cell Phone _____ **Parent's Day Phone** _____

Parent/Guardian Name (print) _____ **Email Address** _____

# of People in Household _____ **Annual Income $** _____

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/development 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:			Has your child's **family** had any of the following:	
YES	NO		YES	NO
☐	☐	Eye Surgery / Injury or Condition	☐	☐ Eye Turn / Lazy Eye
☐	☐	Vision Therapy	☐	☐ Blindness
☐	☐	Headaches	☐	☐ Macular Degeneration
☐	☐	Glaucoma	☐	☐ Glaucoma
☐	☐	Diabetes	☐	☐ High Blood Pressure
☐	☐	Sickle Cell	☐	☐ Sickle Cell
☐	☐	Asthma	☐	☐ Other

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A DIVISION OF MIAMI LIGHTHOUSE

Please explain any "YES" answers from above: _____

Consent for eye examinations - By signing below, I authorize the 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 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 FHCVP because of accident or mishap involving the participation of my child/ward in the program.

LEGAL GUARDIAN SIGNATURE (to receive exam) _____ **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 2.25.2019