2021-2022 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: _____ Teacher _____** **Referring school or agency: _____** **Private must list scholarship: _____** **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? _____
☐	☐	Require any auxiliary aids (such as interpreter, visual aids, wheelchair, Braille)

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

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

Please explain any "YES" answers from above: _____

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

Obligations of Activity Participants Waiver, Release &Hold Harmless

COVID-19 and Voluntary Third-Party Extracurricular Activities
Summer 2020 and School Year 2021-2022

Extra-Curricular Activity: Florida Heiken Children's Vision Program

Parent/Guardian's Name: _____

Participating Child's Name: _____

I desire to participate or allow my child(ren) ("Activity Participant") to participate in one or more voluntary extracurricular activities being held on the campus(es) of the School Board of Miami-Dade County, Florida ("School Board"). I acknowledge that the novel coronavirus known as COVID-19 has been declared as a worldwide pandemic and is believed to be contagious and spread by person-to person contact, including in Miami-Dade County. I further acknowledge that federal, state, and local agencies recommend social distancing and other measures to prevent the spread ofCOVID-19.

The School Board will have third-party organizations ("Organizations") conducting certain extracurricular activities, including summer camps, on its campus(es) beginning in the Summer of 2020 and continuing into the 2020-21 school year. I understand that if I or my child(ren) choose to participate in these Organizations' activities (hereinafter "Activity"), the Activity will be controlled, organized, contracted, staffed and insured independent of the School Board, and will be conducted with the safety protocols these Organizations deem appropriate under the circumstances at the time, which may be subject to change. I understand that the School Board will not be responsible for implementing, supervising, or informing the Activity Participant(s) of this Organization's safety protocols, and that it is solely my responsibility, as well as the Activity Participant's, to adhere to all state, federal, and local safety protocols, as well as those the Organization provides.

In an effort to ensure the safety and wellness of our school community, I understand the importance of Activity Participants, including my child(ren), being healthy and safe when they participate in the Activity. By signing below, I agree that I will:

- Perform daily temperature checks on my child(ren) to screen for fever before arrival to the Activity. Fever is defined as a temperature over 100.4 F or 38.0 C. If my child(ren) has a fever, I will not permit my child(ren) to participate in the Activity until he/she has been without a fever for at least 72 hours.
- Make a visual inspection of my child(ren) for signs of illness which could include: fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea, flushed cheeks, rapid breathing or difficulty breathing (without recent physical activity), fatigue, or extreme fussiness. If my child(ren) has exhibited any of these signs or symptoms, I will not permit my child(ren) to participate in the Activity until he/she has been without signs or symptoms for at least 72 hours.
- Confirm that my child(ren), before and while participating in the Activity, has not tested positive for COVID-19 in the past 14 days, is not waiting for test results based on a diagnosed or suspected case of COVID-19, and has not within 14 days returned from an area subject to CDC Level 3 Travel Health Notice.
- Confirm that my child(ren), before and while participating in the Activity, has not been in contact with someone who has either tested positive for COVID-19 in the past 14 days, is waiting for test results based on a diagnosed or suspected case of COVID-19, or has returned from a highly impacted area subject to a CDC Level 3 Travel Health Notice. If my child(ren) has been in contact with such a person, including from the same household, I will not permit my child(ren) to participate in the Activity until 14 days have elapsed since the time of contact.
- Promptly pick up my child(ren), or arrange for pickup, if signs or symptoms of illness are present. I understand that children are to remain home until illness-free for at least 72 hours without the use of medicine.

By signing this document, I acknowledge and affirm all of the statements above. I also understand that I or my child(ren) may unavoidably be exposed to or infected by COVID-19 as a result of participation in the Activity, and that such exposure or infection may result in personal injury, illness; sickness, and/or death. I understand that the risk of exposure or infection may result from the actions, omissions, or negligence of myself, my child(ren), these Organizations, School Board staff, volunteers, or agents, other Activity participants, or others not listed, and I acknowledge that all such risks are known to me.

In consideration of my and/or my child(ren) being able to participate in the Activity, I, on behalf of myself and my child(ren), as weU as anyone entitled to act on my behalf, hereby knowingly and voluntarily forever waive, release, and hold the School Board and its employees and agents harmless from any and all claims, suits, liability, actions, judgments, attorneys' fees, costs, and any expenses of any kind resulting from injuries or damages, grounded in tort or otherwise, that I and/or my child(ren), or my or our representatives, sustain during or related to my child(ren)'s participation or involvement in the Activity.

If this Waiver, Release and Hold Harmless or any portion thereof is determined to be invalid or unenforceable for any reason, the remaining provisions of this Waiver, Release, and Hold Harmless, as well as any other agreement(s) concerning my or my child(ren)'s participation in this Activity, shall be unaffected and remain in full force and effect.

_____
Signature of Parent/Guardian

_____
Signature of Activity Participant

_____
Print name of Parent/Guardian

_____
Print name of Activity Participant

_____
Date of signature

_____
Date of signature

FLORIDA HEIKEN
Children's Vision Program, LLC

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

- 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:

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