State of Illinois
Department of Public Health

# DENTAL EXAMINATION WAIVER FORM

**Please print:**

| Student's Name: Last First Middle | | Birth Date: (Month/Day/Year) |
|---|---|---|
| Address: Street City ZIP Code | | Telephone: |
| Name of School: | Grade Level: | Gender: |
| Parent or Guardian: | Address (of parent/guardian): | |

**I am unable to obtain the required dental examination because:**

☐ My child is enrolled in the free and reduced lunch program and is not covered by private or public dental insurance (Medicaid/All Kids).

☐ My child is enrolled in the free and reduced lunch program and is ineligible for public insurance (Medicaid/All Kids).

☐ My child is enrolled in Medicaid/All Kids, but we are unable to find a dentist or dental clinic in our community that is able to see my child and will accept Medicaid/All Kids.

☐ My child does not have any type of dental insurance, and there are no low-cost dental clinics in our community that will see my child.

Signature ______________________________ Date ____________________