

Waiver of Oral Health Assessment Requirement -Buckeye Union School District

Please fill out this form if you need to excuse your child the oral health assessment requirement.
 Sign and return this form to the school where it will be kept confidential.

Section 1: Child's Information (Filled out by parent or guardian)

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|-----------------------------|--|-------------------------------------|--|
| Child's First Name: | Last Name: | Middle Initial: | Child's Birth Date: MM – DD – YYYY |
| Address: | | | Apt.: |
| City: | | ZIP code: | |
| School Name: | Teacher: | Grade: | Year child starts kindergarten: Y Y Y Y |
| Parent/Guardian First Name: | Parent/Guardian Last Name: | Child's Gender: Male Female | |
| Child's Race/Ethnicity: | <input type="checkbox"/> White <input type="checkbox"/> Native American <input type="checkbox"/> Black/African American <input type="checkbox"/> Multi-racial <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Unknown <input type="checkbox"/> Other (please specify) | | |

Continued on Next Page

Section 2: To be filled out by parent or guardian ONLY IF asking to be excused from this requirement

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| Please excuse my child from the assessment because (check the box that best describes the reason): | |
| <input type="checkbox"/> | I cannot find a dental office that will take my child's dental insurance plan. My child's dental insurance plan is: <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Covered California <input type="checkbox"/> Healthy Kids <input type="checkbox"/> None <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> | I cannot afford an assessment for my child. |
| <input type="checkbox"/> | I cannot find the time to get to a dentist (e.g., cannot get the time off from work, the dentist does not have convenient office hours). |
| <input type="checkbox"/> | I cannot get to a dentist easily (e.g., do not have transportation, located too far away). |
| <input type="checkbox"/> | I do not believe my child would benefit from an assessment. |
| <input type="checkbox"/> | Other (please specify the reason not listed above for why you are seeking a waiver of this assessment for your child): _____ _____ |
| If asking to be excused from this requirement: | |
| <input type="checkbox"/> | MM – DD – YYYY |
| Signature of parent or guardian | Date |

The law states schools must keep student health information private. Your child's name will not be part of any report as a result of this law. This information may only be used for purposes related to your child's health. If you have questions, please call your school.

Return this form to the school *no later than* May 31 of your child's first school year.

Original to be kept in child's school record.