



DENTAL EXAMINATION WAIVER FORM

Please print:

Student's Name:		Last	First	Middle	Birth Date: (Month/Day/Year)
Address:		Street		City	ZIP Code
Name of School:		ZIP Code		Grade Level:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Parent or Guardian:		Last Name		First Name	
Student's Race/Ethnicity:					
<input type="checkbox"/> White	<input type="checkbox"/> Black/African American	<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Asian		
<input type="checkbox"/> Native American	<input type="checkbox"/> Native Hawaiian/Pacific Islander	<input type="checkbox"/> Multi-racial	<input type="checkbox"/> Unknown		
<input type="checkbox"/> Other _____					

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 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.

Parent or Guardian Signature _____ Date: _____

Illinois Department of Public Health, Division of Oral Health
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.dph.illinois.gov

