

DENTAL EXAMINATION WAIVER FORM

Please print:

Student's Name:	Last	First	Middle	Birth Date: (Month/Day/Yea
Address: St	reet	City		ZIP Code
Name of School:		ZIP Code	Grade Level:	Gender: ☐ Male ☐ Female
Parent or Guardian:	Last Name		First Name	L Male L Female
	ity: □ Black/African Amer □ Native Hawaiian/Pa	an mana ⊩ a a		☐ Asian ☐ Unknown
A CHINA CANADA CANA				
I am unable to obtain	the required dental e	xamination 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.				
	d Medicaid / All Kids, b hild and will accept Me	ut we are unable to find a der edicaid / All Kids.	tist or dental clinic	in our community that
My child does not he that will see my chi		I insurance, and there are no	low-cost dental clir	nics in our community
Parent or Guardian Sign	nature		Date:	
		A of Dod Pollockie Division		

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

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