State of Illinois Department of Public Health

DENTAL EXAMINATION WAIVER FORM



PI	ea	se	a	ri	n	t

Student's Name:	Last	First	Middle	Birth Date: (Month/Day/Year)			
				/ /			
Address: Street		City	ZIP Code	Telephone:			
Name of School:			Grade Level:	Gender:			
				Male Female			
Parent or Guardian:			Address (of parent/guardian):				
			not covered by private or public	dental insurance			
My child is enrolle	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 will see my child.	have any type of dental	insurance, and there ar	e no low-cost dental clinics in οι	ur community that			
Signature			Date				