

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: <input type="checkbox"/> Male <input type="checkbox"/> Female | |
| 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/KidCare).
- My child is enrolled in the free and reduced lunch program and is ineligible for public insurance (Medicaid/KidCare).
- My child is enrolled in Medicaid/KidCare, 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/KidCare.
- 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 _____

Illinois Department of Public Health, Division of Oral Health
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.idph.state.il.us