## Illinois Department of Public Health DENTAL EXAMINATION WAIVER FORM



## **Please print:**

Student's Name:	Last	First	Middle	Birth Date: (Month/Day/Year) / /
Address: Stre	et	City	ZIP Code	Telephone:
Name of School:			Grade Level:	Gender:
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, 535 W. Jefferson St., Springfield, IL 62761 217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.idph.state.il.us

> Printed by Authority of the State of Illinois P.O.#346086 5M 10/05