

State of Illinois Illinois Department of Public Health

DENTAL EXAMINATION WAIVER FORM

Please print:

Student's Name:	Last First Middle		Middle	Birth Date:	(Month/Day/Year)		
Address: S	treet	City			ZIP Code		
Name of School:		ZIP Code		Grade Level:	Gender:		
					□ Male	□ Female	
Parent or Guardian:	Last Name			First Name			
Student's Race/Ethnicity:							
□ White	🗌 Black/African American		🗆 Hispanic/Latino		🗆 Asian		
Native American	□ Native Hawaiian/Pacific Islar	der 🛛 Multi-racial		Unknown			
□ 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:
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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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