

# 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, 535 W. Jefferson St., Springfield, IL 62761  
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • [www.idph.state.il.us](http://www.idph.state.il.us)