

State of Illinois 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	
Name of School:			ZIP Code	Grade Level:	
Parent or Guardian:	Last Name		First Name		
Select from the below general racial category which most clearly reflects the student's recognition of his or her community or with which the student most identifies.					
White	Black or African Ar	merican 🗖 Hispani	c or Latino	Asian	
American Indian or Alaska Native Native Hawaiian or Pacific Islander Two or More Races					

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 _	
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Date:

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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