DENTAL EXAMINATION WAIVER FORM



| Please print: | | | | | |
|--|--|------|-------|-------------------------------|------------------------------|
| Stu | dent's Name: | Last | First | Middle | Birth Date: (Month/Day/Year) |
| | | | | | 1 1 |
| Add | Iress: Street | | City | ZIP Code | Telephone: |
| | | | | | |
| Name of School: | | | | Grade Level: | Gender: |
| | | | | | Male Female |
| Parent or Guardian: | | | | Address (of parent/guardian): | |
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| | | | | | |
| 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 in 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. | | | | |
| Signature | | | | Date | *1 |