**Section 665.APPENDIX E Illinois Department of Public Health Dental Examination Waiver Form**

**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:  Male  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 or reduced lunch program and is not covered by private or public dental insurance (medical assistance/ALL KIDS).

❑ My child is enrolled in the free or reduced lunch program and is ineligible for public insurance (medical assistance/ALL KIDS).

❑ My child is enrolled in medical assistance/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 medical assistance/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 |  |

(Source: Added at 33 Ill. Reg. 8459, effective June 8, 2009)