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 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

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