



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/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 _____