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/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