## **DENTAL EXAMINATION WAIVER FORM**



## Please print:

Stude	ent's Name:	Last	First	Middle	Birth Date: (Month/Day/Year)
					/ /
Addre	ess: 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	