



Dental Examination Waiver Form

Please print

Student's Name: <i>Last</i>		<i>First</i>	<i>Middle</i>	Birth Date (Month/Day/Year):
Address: <i>Street</i>		<i>City</i>		<i>ZIP Code</i>
School: <i>Name</i>	<i>ZIP Code</i>	Grade Level:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Parent or Guardian: <i>Last Name</i>		<i>First Name</i>		
Student's Race/Ethnicity: <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Middle Eastern or North African <input type="checkbox"/> Two or More Races <input type="checkbox"/> Unknown				

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 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.

Parent or Guardian Signature: _____

Date: _____