Waiver of Oral Health Assessment Requirement

To be filled out by parent or legal guardian ONLY if asking to be excused from this requirement.

I request that my child be excused from the oral health assessment requirement for the following reason: (Please check the box that best describes the reason.)

Insurance Reasons:

☐ I am unable to find a dental office that will take my child's insurance plan.

My child is covered by the following insurance plan:

☐ Healthy Kids ☐ Medi-Cal/Dental-Cal ☐ Covered California
☐ None ☐ Other: _____

Monetary Reasons:

☐ I cannot afford an oral health assessment for my child.

Personal Reasons:

☐ I cannot find the time to get to a dentist (e.g., cannot get time off from work, the dentist does not have convenient office hours) or I cannot get to a dentist easily (e.g., do not have transportation, located too far away).

☐ I do not believe my child would benefit from an assessment.

☐ Other (please specify the reason not listed above for why you are seeking a waiver of this assessment for your child)

_____

_____ _____ _____

Signature of Parent *Print Name* *Date*

The law states schools must keep student health information private. Your child's name will not be part of any report as a result of this law. This information may only be used for purposes related to your child's health. If you have questions, please call your school.

RETURN THIS FORM TO THE SCHOOL NO LATER THAN MAY 31
Original to be kept in student's school health record