IUSD HEALTH SERVICES

WAIVER OF ORAL HEALTH ASSESSMENT

To be completed by parent or guardian

Student's Name: _____ **School:** _____

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.)

☐ 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:
☐ Medi-Cal/Denti-Cal ☐ Healthy Families ☐ Healthy Kids ☐ None
☐ Other _____

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

☐ I do not wish my child to receive an oral health assessment

Other reasons my child could not get an oral health assessment (optional):

_____

_____

California law requires schools to maintain the privacy of student's health information. Your child's identity will not be associated with any report produced as a result of this requirement. If you have any questions about this requirement, please contact your school office.

_____ _____

Signature of parent or guardian **Date**

Please submit by August 24th

Original to be retained in child's school record.

Revised 01-21-2016