

## Iowa Department of Public Health CERTIFICATE OF DENTAL SCREENING EXEMPTION

## This certificate is not valid unless all fields are complete.

A designee of the local board of health or lowa Department of Public Health may review this certificate for survey purposes.

Please Print:		
Student's Last Name:	Student's First	Name: Birth Date (M/D/YYYY):
Parent or Guardian Name:		Telephone (home):
		(mobile):
Address: Street	City:	County:
Name of School:	Gra	ade Level: Gender:
		Female
	Religiou	/S
	to an applicant if the denta	al screening conflicts with a genuine and sincere religio
		st that the dental screening conflicts with a genuine and not based merely on philosophical, scientific, more
		cate of Dental Screening Exemption for religious reaso
is valid only when notarized.	<b>5</b>	
Signature:		Date:
Ctata of:	nt, Parent or Guardian	
State of.		<u> </u>
This instrument was acknowledged be	efore me on: Da	ate By: Name(s) of Person(s)
Signature of Notary Public:		
Title:		
		SEAL OR STAMP
	Financial Har	rdship
	e granted to an applicant w	who is unduly burdened by the cost of a dental screening
		cause a genuine financial burden for the applicant. The must be signed by a dentist, dental hygienist, physicial
physician assistant, or nurse.	ption for financial flatustrip	must be signed by a definist, definal hygienist, physicia
Provider Type:	Date	·
	☐ PA ☐ Nurse	·
Provider Name:	Prov	ider Signature:
Business Address:		
Business Phone:		