



TEAM

DRIVING SCHOOL

Medical Release Form

This form is required for students that have purchased Behind-The-Wheel instruction Student

Name: _____ DOB: _____

Parent/Guardian Name(s): _____

Phone # _____ Phone # _____

Student's # _____

Please check any medical conditions that may affect your student while in class or vehicle:

Diabetes Anxiety Hearing Abnormalities ADD / ADHD Seizures Autism

Respiratory Disease (Asthma etc.) Visual Abnormalities (not corrected by eyewear)

_____ Other _____ (Please Specify): _____

IEP or Classroom Accommodations (Please Specify): _____

Please list any additional information that may be beneficial for the Instructor(s) while teaching your child: _____

In the event a parent or guardian cannot be contacted, I hereby authorize Team Driving School or their designee, to obtain emergency medical care and/or dental care for my child at the nearest medical facility

Parent / Guardian Signature: _____

Date: _____