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 # _____ Alt # _____

Physician's Name: _____Physician's Phone: _____

Dentist's Name: _____ Dentist's Phone: _____

Preferred Hospital: _____ (Depending on the situation, the closest may be used)

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

- ☐ Diabetes
- ☐ Hearing Abnormalities
- ☐ Seizures
- ☐ Respiratory Disease (Asthma etc.)
- ☐ Visual Abnormalities (not corrected by eyewear)
- ☐ Other (Please Specify):_____
- ☐ Anxiety
- ☐ ADD / ADHD
- ☐ Autism

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:_____