PANHANDLE DRIVING SCHOOL

CONFIDENTIAL HEALTH INFORMATION

STUDENT NAME: _____

PARENT/GUARDIAN NAME: _____

PARENT/GUARDIAN CONTACT NUMBER: _____

Please circle below any physical and /or medical limitations you teenager may have:

Hearing Problems	yes	no	Rheumatic Fever	yes	no
Vision Problems	yes	no	Epilepsy	yes	no
Diabetes	yes	no	Fainting Spells	yes	no
Heart Trouble	yes	no	Paralysis	yes	no
Orthopedic Problems	yes	no	Cerebral Palsy	yes	no
Chronic Illness	yes	no	Asthma	yes	no

Other (describe)

_____

_____

Is your teenager taking any medications regularly Yes No

If yes, please list_____

Describe side effects: _____

Does your son/daughter have any specific learning problems (including reading difficulties) which might hinder their progress or limit participation in either classroom or in-car activities? Yes No

If yes, explain _____

_____

Do you wish to schedule a conference with any of the driving instructors? Yes No

_____

Parent/Guardian Signature

Note: Students will not be scheduled for drives until this form has been completed, signed and returned to the instructor.