Traffic Safety Education
Confidential Health Information

STUDENT NAME: _____

PARENT/GUARDIAN NAME: _____

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

Hearing Impairment	Corrective Lenses	Diabetes
Cardiovascular Issues	Orthopedic Issues	Rheumatic Fever
Epilepsy/Seizures	Fainting Spells	Paralysis
Cerebral Palsy	Respiratory Issues	

Other: (describe) _____
_____

Is your student taking any medication regularly including OTC? Yes No
If yes, please describe: _____
_____

Does your son/daughter have any specific learning problems (including reading difficulties) which might hinder or limit participation in either classroom or in-car activities?
Yes No
If yes, please list accommodations I could provide:
_____
_____

Do you wish to schedule a conference with the Traffic Safety Instructor? Y N

Home address: _____
_____
Home phone number: _____
Parent/Guardian work phone: _____
Ext _____

_____
Parent/Guardian Signature

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