



PLEASE PRINT

Student: (last) (first) (middle)

Address: City: Zip:

Home Phone: Age: D.O.B.:

Parent/Guardian's Name: Phone #:

Emergency Contact: Phone #:

ACCOMMODATIONS/MEDICAL CONDITIONS

- 1. Does the student require any special accommodations to participate in the classroom phase...
2. Does the student require any special accommodations to participate in the behind-the-wheel phase...
3. Is the student taking any medications that may affect his/her ability to drive a motor vehicle safely?
4. Are there any medical conditions that would pose a concern with the student's behind-the-wheel instruction...
5. Is the student's visual acuity at least 20/40 corrected?
6. In the last six months, has the student had a fainting spell, blackout, seizure, or other uncontrolled loss of consciousness?
7. In the last six months, has the student had a physical or mental condition which would affect his/her ability to drive a motor vehicle safely?

If the answer to any of questions 5 – 7 is Yes, then the Parent/Guardian must provide a letter signed by the Student's physician indicating that the condition has been corrected and/or is under control and the Student meets the physical and mental requirements for a motor vehicle operator's license under Section 309 of the Michigan Vehicle Code, 1949 PA 300, MCL 257.309.

CERTIFICATION:

I certify that all information contained within this document is true and accurate to the best of my knowledge.

Date: Student Signature:

Date: Parent/Guardian Signature:

Date: Big Rapids Driving Academy, LLC By: Owner
Provider Name Signature of Provider Owner Title