

Student Health Information Sheet

(Triple R Driving School)

*** ANY INFORMATION GIVEN ON THIS FORM WILL BE KEPT CONFIDENTIAL ***

*** *This form **MUST** be returned before any driving can be done.* ***

1. _____
Student's Name **Student's Cell Phone #**

2. _____
Parent / Guardian Name **Parent / Guardian Cell Phone #**

Parent / Guardian Address

3. _____
Physician's Name **Physician's Cell Phone #**

4. Please list any mental or physical problems that could impair the driving ability of the aboved name student :

Symptoms : _____

5. Is the above named student taking any medication now? **Yes** _____ **No** _____

If yes, please state the type of medication, student's condition, and how the medication is likely to affect the student.

If yes, please submit a written approval slip from the doctor clearing the student to drive. It is also necessary to contact the school nurse and inform her/him of the type of medication the student is taking.

It is extremely important that the driver education instructor and the school nurse be informed immediately should the aboved named student find it necessary (under a doctor's care) to take any medication that would affect or impair the driving ability of the student.

Date : _____

Parent's Signature

Student's Signature