Premier Driving Academy Inc.

200 N. Groesbeck Hwy. Mt. Clemens 48043 586-741-3748

**Registration and Health form. Segment I**

Office Hours Mon.-Thurs 6:00 – 8:00 P.M first three weeks of the month

STUDENTS FULL NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last First Middle

ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CITY/ZIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOME PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CELL:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BIRTHDATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(mm/dd/yy)  
Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does the student require any special accommodations to participate in the classroom phase (i.e. test being read to him/her, an interpreter, seating arrangements etc)? Yes\_\_\_\_\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Does the student require any special accommodations to participate in the behind the wheel phase (i.e. adaptive devices, an interpreter, etc.)? Yes\_\_\_\_\_\_ No\_\_\_\_\_  
If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Is the student taking any medications that may affect his/her ability to drive a motor vehicle safely? Yes\_\_\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_  
If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Are there any medical conditions that would pose a concern with the students behind the wheel instruction (i.e. epilepsy, asthma, color blindness, hearing loss)? Yes\_\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Is the student’s visual acuity at least 20/40 corrected? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_\_

6. In the last six months, has the student had a fainting spell, blackout, seizure or other uncontrolled loss of consciousness? Yes:\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_

7. In the last six months, has the student had a physical or mental condition which affected his/her ability to drive a motor vehicle safely? Yes:\_\_\_\_\_\_\_\_ No:\_\_\_\_\_\_\_\_\_\_\_

If the answer to question 5 is no, or either of questions 6 or 7 is yes, then the parent/guardian must provide a letter signed by the students physician indicating that the condition has been corrected and/or is under control, and the student meets the physical and mental requirements for motor vehicle operator’s license under Section 309 of the Michigan Vehicle Code, 1949 PA 300, MCL. 257-309

Certification: I certify that the information on this form is True and Accurate to the best of my knowledge.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YY)

Parent Signature