



**Gold Star Driving School LLC**  
**DRIVER EDUCATION**  
**CONFIDENTIAL HEALTH & WELLNESS INFORMATION**

STUDENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

PARENT(S)/GUARDIAN(S) NAME(S): \_\_\_\_\_

PARENT(S)/GUARDIAN(S) WORK #(s): \_\_\_\_\_

HOME #(s) \_\_\_\_\_ Cell #(s) \_\_\_\_\_

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

Hearing Problems	Yes	No	Dyslexia	Yes	No	Allergic Reactions	Yes	No
Vision Problems	Yes	No	Epilepsy	Yes	No	ADD - ADHD	Yes	No
Diabetes	Yes	No	Fainting Spells	Yes	No	Anxiety	Yes	No
Reading	Yes	No	Note Taking	Yes	No	Comprehension	Yes	No
Heart Trouble	Yes	No	Paralysis	Yes	No	Depression	Yes	No
Orthopedic Problems	Yes	No	Chronic Illness	Yes	No	Asthma	Yes	No
Other Illnesses: (describe) _____								

Has your son/daughter ever been in an automobile accident, or had a traumatic experience; where someone was seriously injured or killed. Yes No

If yes, please describe how this effected him/her: \_\_\_\_\_

Is your son/daughter currently taking any medication(s) regularly that may effect their ability to safely operate a motor vehicle or participate in class activities? Yes No

If yes, please list: \_\_\_\_\_

Describe side effects: \_\_\_\_\_

Does your son/daughter have any specific learning problems (including: IEP, anxiety, reading or concentration) which might hinder progress or limit participation in either classroom or behind the wheel activities? Yes No

If yes explain: \_\_\_\_\_

\_\_\_\_\_  
 Parent(s)/Guardian(s) Signature Date

NOTE: Students will not be scheduled for Behind the Wheel until this form has been completed, signed, and returned to Gold Star Driving School LLC.