

# Gold Star Driving School, LLC

## STUDENT APPLICATION FOR DRIVER EDUCATION PROGRAM

(please PRINT the following information)

A \$200 non-refundable deposit is required to hold a spot.

All prices are subject to change without notice.

A fuel surcharge may be implemented if fuel prices continue to rise.

LEGAL NAME: \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Last First Middle Initial Date of Birth

ADDRESS: \_\_\_\_\_  
Street City Zip

EMAIL: \_\_\_\_\_ PHONE: \_\_\_\_\_

CELL #: \_\_\_\_\_

\_\_\_\_\_  
M/F Age Grade School Attending

Course Date Choice: \_\_\_\_\_

Summer Courses 6 weeks Mon-Tue-Wed  
School Year Course 10 weeks Mon & Wed  
Call for Current fees

Behind the Wheel Instruction schedules will be set on Parents night for all courses:  
Student must have Valid Vermont Learner's Permit BEFORE the first class.

VT Learners Permit ID #: \_\_\_\_\_ Date of Issue: \_\_\_\_\_

Course Fee due upon signing this application:

We agree to participate in the Gold Star Driving School LLC, Traffic Safety Driver Education Program. We have read and agree to all terms in order to fulfill the requirements of this course. We further understand that the student is covered under commercial liability insurance both in class and behind the wheel instruction.

\_\_\_\_\_  
Student Signature Parent/Guardian Signature Date

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

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

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

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
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 you son/daughter every 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 student currently taking any medication(s) regularly that may effect their ability to drive?  
 Yes No  
 If yes, please list: \_\_\_\_\_  
 Describe side effects: \_\_\_\_\_

Does your son/daughter have any specific learning problems (including, anxiety, readiug 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

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.