Driver Education Student Information Sheet

Name:____________________ Date of Birth:________________

Address: __________________ Current Age:_________________

__________________________ Home Phone:________________

Learners #_________________ Restrictions_________________

Expiration Date______________

Parents Names____

Parents Email Address____

List any possible medical conditions that could affect your ability to drive safely: (Ex: Vision or hearing problems, epilepsy, diabetes, etc.)

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Are you currently taking any daily medications? If yes, list below and explain the purpose.

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Driving Experience:

On a scale of 1-10, with one being zero to almost zero driving experience and 10 meaning, I could pass the on-road driving test tomorrow, and I would be willing to take an F in class if I did not actually pass it, please give yourself a score on your driving comfort level.

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