Medical Release

Student Name _____

Allergies / Medications / Medical Conditions that may affect the student's driving:

Physician of Choice _____

Phone Number _____

Hospital of Choice _____

Phone Number _____

Dentist of Choice _____

Phone Number _____

Parent / Guardian Contact Name _____

Number _____

In the event that neither the parent, guardian, nor the medical personnel listed above can be contacted, I hereby authorize Behind the Wheel School of Driving or its designee to obtain emergency medical care for the student named above when, in the opinion of a physician or surgeon licensed under the provisions of the Medical Practice Act, such care will be for the best interest of the student and should not be delayed pending consent of the parents, guardian, or family physician. I understand that Behind the Wheel School of Driving has insurance that pays for the medical or hospital costs that might be incurred on behalf of the student during the behind-the-wheel instruction in its vehicles. I understand that all such costs incurred by the student during behind-the-wheel instruction **in your family vehicle** shall be my sole responsibility and consequently I release Behind the Wheel School of Driving from any such costs.

Parent / Guardian Signature _____ Date _____

Behind the Wheel Rep ______________________________ Date _________________