Name of Provider: RIGHT TURN DRIVING SCHOOL

**SEGMENT 1 REGISTRATION FORM**

Please Print

STUDENT FULL NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last First Middle

ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ZIP CODE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HOME PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BIRTHDATE:\_\_\_\_\_\_\_\_\_\_\_\_\_ ***VERIFIED BY BIRTH CERTIFICATE***

Student must be at least 14 years and 8 months by the first day of class.

PARENT/GUADIAN'S NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WORK PHONE:\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does the student require any 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 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 explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Are there any medical conditions that would pose a concern with the student's behind the wheel instruction (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, seizures, 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 the condition has been corrected and/or is under control, and the student meets the physical and mental requirements for a 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 most accurate to the best of my knowledge.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PARENT SIGNATURE STUDENT SIGNATURE DATE