PRO DRIVING SCHOOL INC.

13__

Please print the information :

Applicants Name: _____ Date: ____/_____/_____

Address: _____ City: _____ State: **OHIO**

County: _____ Zip: _____ Gender: _____

Home Phone: (____)_____ Student Cell Phone: (____)_____

High School: _____ Date of Birth: _____/_____/_____

(Must be at least 15 years and 5 months of age to start)

E-mail address:

_____

License #: _____ Issue Date: _____ Exp Date: _____

Receipt # 1 _____ Cash / Credit / Check Amount: _____ Check Number_____

Receipt # 2 _____ Cash / Credit / Check Amount: _____ Check Number_____

Medical Release Form

This form is required before students may participate in the car portion of Driver Education.

Student Name _____ Age _____

Parent / Guardian Name _____ Cell phone _____

Doctor's Name _____ Parent's Work Phone _____

Hospital _____ Doctor's Phone _____

My child has the following medical conditions that may affect him/her in the car: _____

_____

In the event neither parent nor the doctor listed above can be contacted, I hereby authorize Pro Driving School or his designee to obtain emergency medical care for my child when, in the opinion of a physician and surgeon license under the provisions of the Medical Practice Act, such medical care will be for the best interest of the child and should not be delayed pending consent of the parents or family doctor. I understand that Pro Driving School has insurance which pays for the medical or hospital costs that might be incurred on behalf of my child while in an accident in our car.

Parent / Guardian Signature _____ Date _____/_____/_____