

# PRO DRIVING SCHOOL, INC.

dba PRO DRIVING SCHOOL-BEDFORD, LLC

1329

692 BROADWAY AVE BEDFORD, OHIO 44146

440-232-7060

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Please print all information as on temporary permit:

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: \_\_\_\_\_

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Receipt # 1 \_\_\_\_\_ Cash / Credit / Check Amount: \_\_\_\_\_ Check Number \_\_\_\_\_

Receipt # 2 \_\_\_\_\_ Cash / Credit / Check Amount: \_\_\_\_\_ Check Number \_\_\_\_\_

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

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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 \_\_\_\_/\_\_\_\_/\_\_\_\_

