

**SEGMENT 1 REGISTRATION FORM: Yates 2 Driving School, Inc.**

**Circle Month of Class desired**

*September/October*

*November/December*

*February/March*

*April/May*

*June*

*July*

*August*

**Send with \$25 deposit to**

**Yates 2 Driving School, Inc, 3575 West Harrison, Alma, Michigan 48801**

**Please Print**

STUDENT FULL NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ Last First Middle  
CITY: \_\_\_\_\_

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

BIRTHDATE: \_\_\_\_\_

**VERIFIED BY BIRTH CERTIFICATE**

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

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

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

1. Does the student require any special 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 any 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 describe \_\_\_\_\_

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, seizure, 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 student's physician indicating that 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 accurate to the best of my knowledge.

\_\_\_\_\_  
PARENT SIGNATURE/Date

\_\_\_\_\_  
STUDENT SIGNATURE