Name:_____DOB:_____Exam Date:_____

Medical Examination Form
for Idaho Driver Education Instructors

IDAPA 08.02.02.004 Section 3 Medical Examination

Public driver education and training instructors shall have a medical examination performed by a certified medical professional. The medical examination report must indicate whether the applicant has any ailment, disease, or physical or mental disabilities that may cause momentary or prolonged lapses of consciousness or control, which is or may become chronic. Applicants must not be suffering from a physical or mental disability or disease that may prevent the applicant from maintaining reasonable and ordinary control over a motor vehicle or that could impair the applicant's ability to drive safely or instruct automobile drivers.

Section 1. Driver Information (to be filled out by the driver)

PERSONAL INFORMATION:

Last Name:_____First Name:_____Middle Initial:_____

Date of Birth:_____Driver's License Number:_____Issuing State:____

Street Address: _____

City:_____State:_____Zip Code:_____

Home/Cell Phone:_____Work Phone:_____

Email: _____

DRIVER HEALTH HISTORY:

Are you currently taking any medications *(prescription, over-the-counter, herbal remedies, diet supplements)*?

Medication	Dosage	Times per day

Have you ever had a surgery?

Type of Surgery	Month/Year

Name:_____DOB:_____Exam Date:_____

Do you have or have you ever had: Yes No Not Sure

Do you have or have you ever had:	Y	N	NS
1. Head/brain injuries or illnesses *(e.g., concussion)*			
2. Seizures, epilepsy			
3. Eye problems *(except glasses or contacts)*			
4. Ear and/or hearing problems			
5. Heart disease, heart attack, bypass, or other heart problems			
6. Pacemaker, stents, implantable devices, or other heart procedures			
7. High blood pressure			
8. High cholesterol			
9. Chronic (long-term) cough, shortness of breath, or other breathing problems			
10. Lung disease			
11. Kidney problems, kidney stones, or pain/problems with urination			
12. Stomach, liver, or digestive problems			
13. Diabetes or blood sugar problems Insulin used			
14. Anxiety, depression, nervousness, other mental health problems			
15. Fainting or passing out			
16. Dizziness, headaches, numbness, tingling, or memory loss			

	Y	N	NS
17. Unexplained weight loss			
18. Stroke, mini-stroke (TIA), paralysis, or weakness			
19. Missing or limited use of arm, hand, finger, leg, foot, toe			
20. Neck or back problems			
21. Bone, muscle, joint, or nerve problems			
22. Blood clots or bleeding problems			
23. Cancer			
24. Chronic (long-term) infection or other chronic diseases			
25. Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring			
26. Have you ever had a sleep test *(e.g., sleep apnea)*			
27. Have you ever spent a night in the hospital			
28. Have you ever had a broken bone			
29. Have you ever used or do you now use tobacco			
30. Do you currently drink alcohol			
31. Have you used an illegal substance within the past two years			
32. Have you ever failed a drug test or been dependent on an illegal substance			

Section 2. Examination (to be filled out by the medical examiner)

TESTING

Height: _____feet _____ inches
Weight: _____ pound
Pulse rate: _____
Blood Pressure: _____/_____
Urinalysis: _____ Sp.Gr.
_____ Protein
_____ Blood
_____ Sugar

Vision:
Acuity
Right eye 20/_____
Left eye 20/_____
Both eyes 20/_____
Horizontal Field of Vision
Right Eye: _____degrees
Left Eye: _____ degrees

PHYSICAL EXAMINATION

Body System	Normal	Abnormal	Body System	Normal	Abnormal
General			Abdomen		
Skin			Genito-Urinary system		
Eyes			Back/Spine		
Ears			Extremities/Joints		
Mouth/Throat			Neurological system (e.g., reflexes)		
Cardiovascular			Gait		
Lungs/Chest			Vascular system		

Name:_____DOB:_____Exam Date:_____

Medical Examination Report

Section 3. Exam Report (to be filled in by the medical examiner after exam)

O Meets standards in **IDAPA 08.02.02.004**; qualifies for a 2-year certificate

O Meets standards, but periodic monitoring required *(specify reason)*: _____

Driver qualifies for: O 3 months O 6 months O 1 year

O Does not meet standards *(specify reason)*: _____

This Medical Exam Expires on:

I have performed this evaluation for certification. I have personally reviewed all available records and recorded information pertaining to this evaluation, and attest that to the best of my knowledge, I believe it to be true and correct.

Medical Examiner's Signature: _____

☐ MD ☐ DO ☐ DC ☐ PA ☐ Other: _____

Medical Examiner's Name *(please print or type)*: _____

Medical Examiner's Address: _____

City: _____ State: _____ Zip Code: _____

Medical Examiner's Telephone Number: _____

Instructor: Please submit **ONLY** the **Medical Examination Report** on **Page 3** of this Exam to the Idaho State Department of Education