

# Deerfield Community School District

**Excellence and Equity in Education**



## Appendix P(3) Driver Physical Questionnaire Required Every 3 Years

The following physical exam questionnaire must be completed every three years by any contracted district employee transporting students. If any of the items covered in this questionnaire cannot be passed by the prospective driver, the driver shall be referred to a physician for further examination.

Name of Driver: \_\_\_\_\_

Birthdate of Driver: \_\_\_\_/\_\_\_\_/\_\_\_\_

To be completed by applicant:

1. Yes \_\_\_\_\_ No \_\_\_\_\_ I have insufficient use of both hands and the foot normally employed to operate the foot brake and foot accelerator
2. Yes \_\_\_\_\_ No \_\_\_\_\_ I have had my eyes examined by either the motor vehicle department or a private physician for my driver's license renewal and have restrictions that prevent my operation of a motor vehicle
3. Yes \_\_\_\_\_ No \_\_\_\_\_ I have difficulty hearing, with or without a hearing aid a forced whisper voice at 5 feet.
4. Yes \_\_\_\_\_ No \_\_\_\_\_ I have an established history or clinical diagnosis of diabetes mellitus currently requiring any hypoglycemic agent for control.
5. Yes \_\_\_\_\_ No \_\_\_\_\_ I have a current diagnosis of myocardial infarction, angina pectoris, coronary insufficiency, thrombosis, or any other cardiovascular disease or a variety known to be accompanied by syncope, collapse, or congestive cardiac failure.
6. Yes \_\_\_\_\_ No \_\_\_\_\_ I have an established medical history or clinical diagnosis of a respiratory dysfunction likely to interfere with my ability to control and drive a motor vehicle safely.
7. Yes \_\_\_\_\_ No \_\_\_\_\_ I have a clinical diagnosis of high blood pressure likely to interfere with the safe operation of a motor vehicle.
8. Yes \_\_\_\_\_ No \_\_\_\_\_ I have an established medical history or clinical diagnosis of rheumatic, arthritic, orthopedic, muscular, neuromuscular, or vascular disease which interferes with the safe control and operation of a motor vehicle.
9. Yes \_\_\_\_\_ No \_\_\_\_\_ I have an established medical history or clinical diagnosis of epilepsy or any other condition which is likely to cause loss of consciousness or any loss of ability to control a motor vehicle safely.

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10. Yes \_\_\_\_\_ No \_\_\_\_\_ I have a mental, nervous, organic, or functional disease or psychiatric disorder likely to interfere with the safe operation of a motor vehicle.
11. Yes \_\_\_\_\_ No \_\_\_\_\_ I have used amphetamines, narcotics, or any other habit forming or mind altering drugs within the last two (2) years.
12. Yes \_\_\_\_\_ No \_\_\_\_\_ I am currently using prescription medication which is likely to interfere with the safe operation of a vehicle.
13. Yes \_\_\_\_\_ No \_\_\_\_\_ I have a current clinical diagnosis of alcoholism.
14. Yes \_\_\_\_\_ No \_\_\_\_\_ I have been convicted of reckless driving or driving while under the influence within the last two (2) years.

To the best of my knowledge, the information supplied above by me is accurate and complete:

Signature of applicant: \_\_\_\_\_ Date: \_\_\_\_\_

**Completed by Nurse/Administrator:**

\_\_\_\_\_ The driver applicant has not listed any conditions that would impair driving a motor vehicle.

\_\_\_\_\_ Question(s) have been answered "Yes", refer to the building administrator for possible referral to a physician.

Nurse/Administrator Signature: \_\_\_\_\_

Nurse/Administrator Name: \_\_\_\_\_

Date: \_\_\_\_\_

Original – To Business Manager