KANSAS STATE DEPARTMENT OF EDUCATION

Form No 0-416-100 (rev. 3.31.2021)

KANSAS STATE DEPARTMENT OF EDUCATION
DRIVER TRAINING SCHOOL INSTRUCTOR
PHYSICAL EXAMINATION AND HEALTH CERTIFICATE

Please return this completed form to Driver Education, rmeinholdt@ksde.org KSDE- Driver Education, 900 SW Jackson St, Suite 106, Topeka, KS 66612

Name _____ Date _____

Address _____ Phone #(____) _____

Email: _____ Date of Birth _____ Age _____

Sex	Height	Weight	Hair	Eyes

To be Completed by Physician

The person named above is applying for a driver training school instructor license and is required by law to submit a physical examination upon request. Please complete this form in full and return it to the applicant.

Health History:

Yes	No		Yes	No	
☐	☐	Asthma	☐	☐	Any other nervous disorder
☐	☐	Psychiatric disorder	☐	☐	Tuberculosis
☐	☐	Extensive confinement by illness or injury	☐	☐	Seizures, fits, convulsions, fainting
☐	☐	Kidney	☐	☐	Suffering from any other disease
☐	☐	Head or spinal injuries	☐	☐	Muscular disease

If answer to any of the above is yes, explain: _____

Yes	No	
☐	☐	Vision abnormalities or eye disease (not correctable by eyeglasses)
☐	☐	Cardiovascular disease (e.g., stroke, angina, heart failure, hypertension)
☐	☐	Respiratory disease (e.g. emphysema, asthma)
☐	☐	Diabetes mellitus and/or other endocrine disorders
☐	☐	Impairment due to alcohol or drugs
☐	☐	Blood pressure
☐	☐	Heart and/or circulatory system disorder
☐	☐	Hearing abnormality
☐	☐	Restricted use of any extremity
☐	☐	Speech defect that would prevent giving clear directions or commands
☐	☐	Physical, mental, emotional condition which would affect ability to instruct others in the operation of a motor vehicle
☐	☐	Any communicable disease
☐	☐	Presently on medication-state reason and possible side effects _____

Would present medication affect the person's ability to instruct student(s)? _____

Comments: _____

I, the undersigned physician, found nothing during the examination of the applicant that would interfere with his/her duties as a driving instructor. I will approve him/her as physically fit to be a driver training instructor.

X _____ _____ _____

PHYSICIAN'S SIGNATURE | DATE | PHYSCIAN'S NAME – PRINTED

_____

STREET ADDRESS | CITY | STATE | ZIP | PHONE