DRIVING CONTRACT

Getting a driver's license is an exciting and long awaited time, but driving carries a lot of responsibility. As your Diabetes Team at Akron Children's Hospital, we are excited to see- you enter this new phase of independence. We want you to be a safe driver. To be a safe and responsible driver, you have to be in control of your diabetes. Both low and high blood sugars can affect your driving.

These are the requirements to sign the medical evaluation form:

***Your hemoglobin A1C must be below 9 percent. The original driver's form from the State of Ohio will be signed on a yearly basis if your Hemoglobin A1C is 6-7.9 percent and every six months if your A1C is between 8-9 percent. Evidence of severe glycemic management will also be taken into consideration when signing the driver's form. If driving contract is not followed your provider may contact the Bureau of Motor Vehicles.**

You agree to do the following by signing below:

1. **Test your blood sugar 4 times per day AND before getting behind the wheel. If your blood sugar is less than 100mg/dl, have a small snack before driving.**
2. **Take insulin as prescribed.**
3. **Have something in your car within reach of you to eat (glucose tabs, glucose gel) if you feel low.**
4. **Pull over immediately to test yourself if you feel low. If you are less than 70mg/dl, eat and do not resume driving until 30 minutes after your blood sugar has returned to greater than 100mg/dl.**
5. **On long trips, test your blood sugar every 2-3 hours and do not miss your regular meals or snacks.**
6. **Wear your seatbelt.**
7. **Obey the traffic laws.**

Patient Signature:_____Date:_____

Parent Signature:_____Date:_____

Witness Signature:_____Date:_____

HAVE A SAFE AND FUN DRIVING EXPERIENCE!!!!!!!

Akron Children's Hospital

Steps to obtain signed drivers form

1. **Discuss interest in driving with your parent and provider.**
2. **Sign a new driving contract every year.**
3. **Sign a medical release of information to the Bureau of Motor Vehicles.**
4. **Either mail or bring in "*ORIGINAL*" Bureau of Motor Vehicle form to the office.**
5. **Once requirements are met and your provider approves driving, please allow 10 days to complete paperwork.*Please note we do not mail forms directly to the Bureau of Motor vehicles. Please indicate whether you will pick up the forms or prefer them to be mailed to the home.**
6. **Driving contract will also need to be signed for temporary permit.**

Akron Children's Hospital

HIPAA AUTHORIZATION to RELEASE MEDICAL RECORDS (FROM Children's)

Please PRINT and fill out entirely.

MRN

_____

Facility Use Only

Patient Information

Patient Name: _____
Last First Middle (any previous name) Date of Birth

_____
Patient Street Address City State Zip Phone

Release To

Release Information TO the following Person(s) or Organizations:

Name/Organization: Ohio Bureau of Motor Vehicles Attention: Special Case/Medical Unit

PO Box 16784 Columbus OH 43216-6784
Address City State Zip

_____ _____
Phone Fax Email Address

Purpose

Person/Place requesting records (check all that apply):

☑ Patient/Parent/Legal Guardian ☐ Doctor/Hospita ☐ Lawyer ☐ Insurance Company ☐ Other _____

Purpose of Release (check all that apply):

☐ Patient Care ☐ Disability ☐ Insurance ☐ School ☑ Legal ☐ Personal Use ☐ Other _____

Method of Release

Format of records to be released:

☐ on paper ☐ PDF [on CD or Jump Drive (if available)] ☐ Verbal communication only with person or agency listed above

Information May Be Sent Via: (*Note: Radiology images can only be placed on CD and mailed or picked-up)*

☐ Mail Delivery ☐ Fax ☐ Pick Up ☐ Encrypted Email ☐ to MyChart* (*electronic records only, size restrictions apply)

Information to Release

Dates of Treatment Requested: _____ (If not specified, the **LAST 6 MONTHS** will be released)

☐ **Medical Record Abstract** – pertinent information generally used for continued care/personal use/disability.

The following items are included in a Medical Record Abstract:
After Visit/Discharge Summary, Emergency Record
History & Physical, Inpatient Consult Report(s)
Operative Report(s), Radiology Reports,
Lab or Other Tests

Other Information Requested (choose any to release):

☐ Vaccination (shot) records
☐ Radiology Reports
☐ Radiology Images on disc
☐ Lab results (blood work)
☐ Pathology Report
☐ ACHP Records (specify ACHP): _____
☐ Billing Records
☐ Appointment list
☐ Demographics page

☑ **Doctor's Office Reports** (Doctor or Department Name) Endocrinology

☐ **Other**: (please list exact documents) Diabetes

Patient/Parent/Legal Guardian

This authorization expires **one year** from the date of signature, OR on this date / event: _____

I understand that treatment does not depend on me signing this Authorization. I understand that my/my child's/my ward's medical record might have information about sexually transmitted disease (STDs), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It might also have information about mental health problems or services, and/or treatment for alcohol or drug abuse. I understand that if I release records to someone other than a doctor, insurance company, hospital or other health-related organization, these records may no longer be protected by the Federal privacy regulations, and this person or organization might release the records to someone else, except as prohibited by 42 CFR Part 2 or other applicable law. I understand that I can revoke or cancel this Authorization at any time, but this does not apply to records that were already released. If I want to revoke it, I must notify the Privacy Officer, in writing, at Akron Children's Hospital, One Perkins Square, Akron, OH 44308.

By signing below, I affirm that I am the patient and/or the patient's personal representative, and have the authority to authorize who may access or receive the patient's health information.

_____ _____
Signature of Patient or Parent/Legal Guardian **Printed Name** **Date**

My relationship to the patient is ☐ Self ☐ Parent ☐ Legal Guardian – Attach Court Order to show your authority to sign

_____ _____
Signature of Witness **Printed Name** **Date**

Submit

Submit **completed form** AND a **copy of a valid Photo ID (if a current one is not on file with us)** to:

Mail form to:	**Fax** form to:	**Email** form to:	**Questions? Call**:
Akron Children's Hospital One Perkins Sq., Akron, OH 44308 Attn: Endocrinology	330-543-8489		330-543-3276

Rev. 7/2019

Print for signature Save form