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.**

HIPAA AUTHORIZATION to RELEASE MEDICAL RECORDS

(**FROM** Children's)

Facility Use Only

MRN _____

PATIENT Name _____ Date of Birth _____
Last First MI

Address _____ Phone _____
Street City State Zip

Release TO the following Person(s) or Organizations:

Name: Ohio Bureau of Motor Vehicles

Address: _____
Street City State Zip

Phone: _____ ***Fax:*** _____

Person or Place that is requesting records:

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

Reason records are needed:

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

Release the records checked below, ☐ verbally ☑ on paper **or** ☐ electronically (Cd or Jump Drive, if available) ☐ to MyChart (if available. Parent/Legal Guardian needs to have MyChart Proxy access)

☐ Visit/Discharge summary ☐ Surgery report ☐ Pathology report
☐ Emergency room report ☐ Radiology reports (x-rays, MRI, CT scans) ☐ images on disc ☐ Billing records
☐ Vaccination (shot) records ☐ Doctor's office reports [Doctor or **Department** name_____]
☐ Lab results (blood work) ☑ Other Diabetes
☐ Entire chart* - includes all hospital departments and ACHP records (physician notes, surgery reports, consults, OT/PT/Speech ancillary records, emergency room reports, discharge summaries, after visit summaries, immunization records, radiology reports, labs reports)

***Please note**: This can be hundreds or thousands of pages.

Treatment dates *(if not specified, **the LAST 6 MONTHS** will be released)*:_____

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.

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.

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

Print for signature

My relationship to the patient is:

☐ Parent ☐ Legal Guardian * ☐ Self ☐ Other _____

***Attach Court Order to show your authority to sign.**

_____ _____ _____
Signature of Witness Printed Name Date