Per 1 CCR 301.26, 4204-R-5.02(d) The operator shall annually complete the CDE Multifunction/Small Vehicle Operators Medical Information form (STU-17). Any yes annotations shall require a physician’s release.

Operator Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ New Operator \_\_\_\_\_Yes \_\_\_\_\_No

District/Contractor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ District Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Operator Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Phone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently have any of the following conditions?

\_\_\_\_\_Yes \_\_\_\_\_No Head/Brain injuries or disorders

\_\_\_\_\_Yes \_\_\_\_\_No Seizures/Epilepsy

\_\_\_\_\_Yes \_\_\_\_\_No Eye Disorders or Impaired Vision (except corrective lens)

\_\_\_\_\_Yes \_\_\_\_\_No Ear Disorders or Loss of Balance

\_\_\_\_\_Yes \_\_\_\_\_No Heart Disease/Heart Attack or other Cardiovascular Condition

\_\_\_\_\_Yes \_\_\_\_\_No Heart Surgery (Valve replacement, bypass, angioplasty, pacemaker

\_\_\_\_\_Yes \_\_\_\_\_No High Blood Pressure (DOT standards)

\_\_\_\_\_Yes \_\_\_\_\_No Muscular Disease

\_\_\_\_\_Yes \_\_\_\_\_No Shortness of Breath

\_\_\_\_\_Yes \_\_\_\_\_No Lung Disease, Emphysema, Asthma, Chronic Bronchitis

\_\_\_\_\_Yes \_\_\_\_\_No Kidney Disease

\_\_\_\_\_Yes \_\_\_\_\_No Severe Digestive Problems

\_\_\_\_\_Yes \_\_\_\_\_No Diabetes or Elevated Blood Sugar

\_\_\_\_\_Yes \_\_\_\_\_No Nervous or Psychiatric Disorders

\_\_\_\_\_Yes \_\_\_\_\_No Severe Depression

\_\_\_\_\_Yes \_\_\_\_\_No Loss or altered consciousness

\_\_\_\_\_Yes \_\_\_\_\_No Fainting/Dizziness

\_\_\_\_\_Yes \_\_\_\_\_No Stroke or Paralysis

\_\_\_\_\_Yes \_\_\_\_\_No Chronic Low Back Pain

\_\_\_\_\_Yes \_\_\_\_\_No Sleep Disorder/Apnea/Daytime/Sleepiness/Loud Snoring

\_\_\_\_\_Yes \_\_\_\_\_No Other – Please explain

If you indicated “yes” on any of the above listed questions, a physician’s release is required and shall be maintained in a district file, prior to transporting students in a school transportation vehicle.

I certify that the above information was provided voluntarily and is complete and true. I understand that failure to accurately complete this form will exclude me from driving a school transportation vehicle while transporting students.

Operator Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Transportation Official \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_