

FOR HONOR FLIGHT USE ONLY Last Name: _____ Date Received: ___/___/___



VETERAN APPLICATION

Honor Flight Network recognizes American veterans for your sacrifices and achievements by taking you to Washington, DC to see YOUR memorials at no cost to you. Top priority is given to WWII and terminally ill veterans from all wars. Honor Flight has expanded to include Korean and Vietnam veterans. For Honor Flight to achieve this goal, guardians fly with the veterans on every flight providing assistance and helping veterans have a safe, memorable and rewarding experience. For what you and your comrades have given to us, please consider this a small token of appreciation from all of us at Honor Flight. For further information, please contact us at (937) 521-2400 or visit us at www.honorflight.org

YOUR FULL NAME: _____ NickName: _____
First Full Middle Name Last (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

County: _____ PHONE: Home: _____ Cell Phone: _____

E-MAIL ADDRESS: _____ DATE OF BIRTH (MM/DD/YYYY): _____ AGE: _____

Gender: (M,F): _____ TEE SHIRT SIZE: (circle one) S, M, L, XL, XXL, XXXL, XXXXL

Is there a specific guardian that you would like to fly with you? What is their name and relationship to you:

HOW DID YOU HEAR ABOUT HONOR FLIGHT? _____

ALTERNATE CONTACT : NAME and Relationship to you: _____

PHONE: _____ E-MAIL: _____

EMERGENCY CONTACT INFORMATION (someone available the day you travel):

NAME: _____ Relationship: _____

Address OR E-Mail Address: _____

PHONE # Primary #: (____) _____ - _____ Secondary/ Cell Phone: (____) _____ - _____

Service History: BRANCH OF SERVICE: _____ RANK: _____

HOME TOWN (from which city and state did you enter the service?): _____

Which Conflict (s) did you serve during: (Please circle ALL that apply) **WWII** **Korean** **Vietnam**

Other Conflict: _____

MEDICAL: INFORMATION PROVIDED WILL **NOT** DISQUALIFY YOU. IT PERMITS US TO ASSESS THE SUPPORT WE NEED DURING THE TRIP. INFO IS FOR HONOR FLIGHT AND MEDICAL PERSONNEL ONLY.

Do you use mobility equipment? YES NO. If YES, please circle device: CANE WALKER WHEELCHAIR SCOOTER
MEDICATIONS (name and how often you take it):

<u>MEDICATIONS</u>	<u>Taken How Often?</u>	<u>Medications</u>	<u>Taken How Often</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

- Do you have any drug allergies? _____

PLEASE COMPLETE BACK PAGE!

- Do you have a history of seizure? **YES/ NO** Please describe what type (i.e. grand mal. Petit mal. other)_____
- How long ago was your last seizure? _____
- If within past 5 years, **STRONGLY** advise you to discuss the trip with your private physician!
- Do you have problems with **motion sickness (sea or air)? YES NO** If yes, is it controlled with medications? **YES / NO**
- If motion sickness is not controlled with medications, we advise you to discuss the trip with your private physician!
- Do you have any **breathing problems?** **YES / NO** If Yes, please describe: _____
- Do you have a home nebulizer machine? **YES / NO** If Yes, you are **STRONGLY** encouraged to discuss the trip with your private physician concerning the use of portable hand- held nebulizers during the trip.
- Do you use **oxygen** at any time? **YES / NO** If Yes, you will need your private physician to write a prescription for oxygen to be used during the flight and during the tour. The prescription should be turned in with the application. Oxygen will be provided on the tour but if a Portable Oxygen Concentrator is needed the Veteran must make those arrangements.
- Do you have a **problem walking the length of a football field** without assistance? **YES / NO** If Yes, please describe the reason (e.g. lung problems, arthritis, heart problems,etc.):_____
- Do you have a history of **open head injuries, sinus problems, or ear problems?** **YES / NO** If Yes, have you flown since the open head injury, sinus or ear problems ocured? **YES / NO** If Yes, did you have any problems? **YES / NO**
- If Yes, it is **STRONGLY** advised you discuss the trip with your private physician. If you have **NEVER** flown since the open head injury, sinus or ear problems, again we **STRONGLY** advise you to discuss the trip with your private physician.
- Do you have a **urostomy or colostomy bag?** **YES / NO** If Yes, please make sure the bag is vented prior to flight. If you do not know if your bag is vented, it is **STRONGLY** advised that you discuss the issue with your private physician.

Additional Comments or Concerns:

PLEASE REVIEW CAREFULLY AND SIGN

The undersigned acknowledges and agrees that:

1. As photographic and video equipment are frequently used to memorialize and document Honor Flight trips and events, his/her image may appear in a public forum, such as the media or a website, to acknowledge, promote or advance the work of the Honor Flight program. I hereby release the photographer and Honor Flight from all claims and liability relating to said photographs. I hereby give permission for my images captured during Honor Flight activities through video, photo, or other media, to be used solely for the purpose of Honor Flight promotional material and publications, and waive any rights or compensation or ownership thereto.
2. I further state that medical insurance is the responsibility of the veteran and I understand that Honor Flight does NOT provide medical care. I understand that I accept all risks associated with travel and other Honor Flight activities and will not hold Honor Flight responsible for any injuries incurred by me while participating in the Honor Flight program.

SIGNED: _____ DATE: ____ / ____ / ____

(E-Mail applicants will be required to sign prior to actual flight date)

Please submit this form to : Southern Coffey County High School
Attn: Honor Flight
Box 188, 1010 N. Main St.
Le Roy, KS 66857