

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



VETERAN APPLICATION

Honor Flight Network recognizes American veterans for your sacrifices and achievements by having you to Washington, DC to see YOUR memorial at no cost. Top priority (for which we are currently accepting application only) is given to WW II and terminally ill veterans from all wars. Honor Flight will be 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 a (937) 521-2400 or visit us at www.honorflight.org.

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

GENDER (M , F) _____ ADDRESS _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: Day: _____ Evening: _____ Cell Phone: _____

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

HOW DID YOU HEAR ABOUT HONOR FLIGHT? _____
_____ TEE SHIRT SIZE: (S. M. L, XL, XXL, XXXL) _____

ALTERNATE CONTACT (son, daughter, etc): NAME: _____

PHONE: _____ E-MAIL: _____ RELATIONSHIP: _____

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

Name: _____ Relationship: _____

Address: _____

PHONE: Day: _____ Evening: _____ Cell Phone: _____

SERVICE HISTORY: BRANCH OF SERVICE: _____ RANK: _____

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

ACTIVITY DURING WWII: _____

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>MEDICATION</u>	<u>TAKEN HOW OFTEN?</u>	<u>MEDICATION</u>	<u>TAKEN HOW OFTEN?</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have any **drug allergies**? _____

Do you have a history of seizure? YES NO Please describe what type (i.e. grand mal. petit mal. other) _____

When was your last seizure? _____. If within past 5 years, STRONGLY advised you discuss trip with your private physician!

PLEASE COMPLETE BACK PAGE!

Do you have **motion sickness (sea or air)**? YES NO If yes, is it controlled with medications? YES NO
If motion sickness is not controlled with medications, it is **STRONGLY** advised you discuss the trip with your private physician!

Do you have any **breathing problems**? YES NO. If YES, please describe: _____

Do you use 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. Oxygen will be provided. The prescription should be turned in with the application.

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 occurred? YES NO. If YES, did you still 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 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 this 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 purposes 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: Honor Flight, Inc.
ATTN: Veteran Application
300 E. Auburn Ave.
Springfield, OH 45505-4703
Or fax to: (937) 521-2580**