



Last Name: _____ Date Received: _____

Veteran Application

Honor Flight recognizes American veterans for your sacrifices and achievements by flying you to Washington, DC to see YOUR memorial at **no cost**. Top priority is given to WW II and terminally ill veterans from all wars. In the future, **Honor Flight** will be expanded to include Korean and Vietnam veterans. In order 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**.

YOUR NAME: _____ NICKNAME: _____
(Use your full name as it appears on your driver's license or government ID)

ADDRESS: _____ GENDER: M F

CITY: _____ COUNTY: _____ STATE: _____ ZIP: _____

PHONE: Day: _____ Evening: _____ Cell: _____

EMAIL: _____ AGE: _____ DOB: _____

HOW DID YOU HEAR ABOUT HONOR FLIGHT? _____

_____. T-SHIRT SIZE: (S,M,L,XL,2XL,3XL,4XL) _____

PREFERRED DEPARTING AIRPORT: _____

ALTERNATE CONTACT

NAME: _____ RELATIONSHIP: _____

PHONE: _____ E-MAIL: _____

EMERGENCY CONTACT INFORMATION (Someone available on the day you travel)

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ STATE: _____

PHONE: DAY _____ EVENING: _____ CELL: _____

BRANCH OF SERVICE: _____ RANK: _____ SERVICE DATES: _____

HOMETOWN: (City and State from which you entered the military) _____

ACTIVITY DURING SERVICE: _____

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: CANE | WALKER | WHEELCHAIR | SCOOTER | OTHER _____

MEDICATION	HOW OFTEN TAKEN	MEDICATION	HOW OFTEN TAKEN
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have any **Drug Allergies**? ____ YES ____ NO

If yes, please describe: _____

Do you have a history of **seizures**? ____ YES ____ NO

If YES, please describe (grand mal, petit mal, other) _____

When was you last seizure? _____

If you have had a seizure within the last 5 years, it is strongly advised to discuss travel with your doctor

Do you get **motion sickness**? (sea, air, vehicle) ____ YES ____ NO

If YES, is it controlled with medication? ____ YES ____ NO

Do you have any **breathing problems**? ____ YES ____ NO

If YES, please describe: _____

Do you use a **home nebulizer**? ____ YES ____ NO

Do you use **oxygen** at any time? ____ YES ____ NO

If YES, you will need an oxygen prescription from your doctor to be able to use oxygen during the trip. Oxygen will be provided. The prescription should be included with the application.

Do you have a **problem walking** the length of a football field without assistance? ____ YES ____ NO

If YES, please describe (e.g., heart or lung problems, arthritis, etc.) _____

Do you have a history of **open head injuries, sinus problems, or ear problems**? ____ YES ____ NO

If YES, have you flown since the problem? ____ YES ____ NO

If Yes, did you have any problems flying? ____ YES ____ NO

Do you have a **urostomy or colostomy bag**? ____ YES ____ NO

If YES, please ensure the bag is vented prior to flight.

ADDITIONAL COMMENTS OR CONCERNS: _____

***** IF YOU ANSWERED YES TO ANY OF THE MEDICAL QUESTIONS, YOU ARE STRONGLY ADVISED TO DISCUSS THIS TRIP WITH YOUR DOCTOR *****

PLEASE REVIEW CAREFULLY:

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 neither Honor Flight nor the provider of free private aircraft ("Flight Provider") provides medical care. I understand that I accept all risks associated with travel and other Honor Flight Network activities and will not hold Honor Flight, the Flight Provider, or any person appearing or quoted in any advertisement or public service announcement for or on behalf of Honor Flight responsible for any injuries incurred by me while participating in the Honor Flight program.

SIGNED: _____ **DATE:** _____

PLEASE SUBMIT THIS FORM TO: Lone Eagle Flight2020

**ATTN: BLOUNT COUNTY VETERANS FLIGHT GROUP
c/o BLOUNT COUNTY MEMORIAL MUSEUM
P. O. Box 45
204 2nd Street North
Oneonta, AL 35121**