FOR VILLAGES HONOR FLIGHT, INC. USE Last Name:_____ Date Received:_____/_____/_____

VETERAN APPLICATION

Villages Honor Flight, Inc. recognizes American veterans for their sacrifices and achievements by taking them to Washington, DC to see THEIR memorial at no cost. Top priority is given to WW II and terminally ill veterans from all wars. Volunteer Guardians will go along 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 Villages Honor Flight, Inc. The name and date of birth provided on this application must match the photo ID you will use on the flight. For further information, please contact us or visit us at www.villageshonorflight.org.

YOUR FULL NAME _____ NICK NAME_____
First Name Full Middle Name Last Name (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? _____
_____

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: _____DATES OF SERVICE_____RANK: _____

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

ACTIVITY DURING SERVICE PERIOD: _____

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

1. Do you use MOBILITY EQUIPMENT? YES NO. If YES, please circle device: CANE WALKER WHEELCHAIR SCOOTER

2. MEDICATIONS (name and how often you take it):

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

3. Do you have any DRUG ALLERGIES? If so, what drugs? _____

4. Do you have a history of SEIZURES? YES NO
   If YES, Please describe what type (i.e. grand Mal. petit Mal. other) _____
   When was your last seizure? _____.
   If within past 5 years, it is STRONGLY advised that you discuss trip with your private physician

PLEASE COMPLETE BACK PAGE!

5. 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

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

7. 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.

8. 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.

9. 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.):_____
_____

10. 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.

11. Do you have a uostomy 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:

A. I hereby give permission for my images to be taken or captured during Villages Honor Flight, Inc. through video, photo, or other media, to be used solely for the purposes of Villages Honor Flight, Inc. promotional material and publications, and waive any rights or compensation or ownership thereto.

B. I understand that medical insurance is the responsibility of the veteran and that Villages Honor Flight, Inc does NOT provide medical care. I understand that I accept all risks associated with travel and other Villages Honor Flight, Inc activities and will not hold Villages Honor Flight, Inc responsible for any injuries incurred by me while participating in the Villages Honor Flight, Inc program

C. Check Appropriate Box

- ☐ I have not been to Washington, DC to see my war memorial
- ☐ I have seen my war memorial on my own but have not been on an Honor Flight
- ☐ I have been on an Honor Flight previously

SIGNED: _____

DATE: _____/_____/_____

Please submit this form to: Villages Honor Flight, Inc.
PO Box 490
Lady Lake, FL 32158 – 0490

Please print "Application" in the lower left corner on the front of the envelope

Questions: (352) 259-5890 or
(352) 432-1382