

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

VETERAN APPLICATION



Honor Flight Twin Cities recognizes you, our American veterans, for your sacrifices and achievements by inviting you to Washington, D.C. to see YOUR memorial at no cost. We are currently accepting applications only for WWII Vets who have never been to the Memorial and are not wheelchair bound.

For Honor Flight Twin Cities 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 Twin Cities. For further information, please contact us at crazyjerry45@hotmail.com or 651-481-8835. Thank you for your support.

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

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: Day: _____ Evening: _____ Cell: _____

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

HOW DID YOU HEAR ABOUT HONOR FLIGHT? _____

Have you been to the WWII Memorial in the last 7 years? _____ T-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: _____

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, you are STRONGLY advised 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, you are STRONGLY advised to 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 advised 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 have any problems? YES NO If YES, you are STRONGLY advised to 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, you are 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 Web site, to acknowledge, promote or advance the work of the ***Honor Flight Network*** program. I hereby release the photographer and ***Honor Flight Network*** from all claims and liability relating to said photographs. I hereby give permission for my images captured during ***Honor Flight Network*** activities through video, photo, or other media, to be used solely for the purposes of ***Honor Flight Network*** 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 Network*** or any individual hubs do **NOT** provide medical care. I understand that I accept all risks associated with travel and other ***Honor Flight Network*** activities and will not hold ***Honor Flight Network*** responsible for any injuries incurred by me while participating in the ***Honor Flight Network*** program.

3.

SIGNED: _____

DATE: ____/____/____

Please mail this form to:

Honor Flight Twin Cities/Jerry Kyser
ATTN: Veteran Application
2674 Mackubin Street
Roseville, MN 55113