Veteran Application

Honor Flight recognizes **American WWII, KOREAN WAR and VIETNAM veterans** for your sacrifices and achievements by flying you to Washington, DC to see YOUR memorial at **no cost.** Please consider this a small token of appreciation from all of us at ***Honor Flight***. To be added to our waiting list, please complete and submit the application. For further information, please call **(631) 702-2423.**

We won't call you when we receive your application, we will contact you when it's your turn.

YOUR NAME: _____ NICK NAME: _____

(As it appears on your ID for airline travel) (If Applicable)

ADDRESS: _____CITY: _____ STATE: _____ ZIP: _____

PHONE: _____CELL: _____

E-MAIL ADDRESS: _____**DATE of BIRTH**_____

HAVE YOU SEEN YOUR MEMORIAL? _____T- SHIRT SIZE: (S, M, L, XL, XXL, XXXL)_____

APPROXIMATE WEIGHT_____ HEIGHT_____

SERVICE BRANCH: _____ RANK: _____

ACTIVE SERVICE DATES and LOCATION_____

***Do you have someone who would serve as your GUARDIAN? YES/NO.**

If yes NAME and PHONE NUMBER_____

*** If not Honor Flight will provide a Guardian. Guardians MUST fill out an application and must be "next generation."**

We strongly recommend that Veterans do NOT drive themselves on Flight Day!! Do you know someone who will provide your transportation to and from the airport, Yes or No? If Yes please provide name: _____

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

PHONE: _____ E-MAIL: _____ RELATIONSHIP: _____

EMERGENCY CONTACT INFORMATION (someone available on the ground the day you travel)

Name: _____ Relationship: _____

Address: _____

PHONE: _____ CELL: _____

HOW DID YOU HEAR ABOUT HONOR FLIGHT? _____

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

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, please discuss 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, it is STRONGLY advised you discuss the trip with your private physician!

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

physician concerning the use of portable hand-held nebulizers during the trip.

Do you use **oxygen** at any time? YES NO. If YES, please note you will need to obtain a portable oxygen concentrator and extra batteries. You will also need a prescription from your medical provider ordering the oxygen use. **You cannot use liquid oxygen or compressed gas, *There are companies who rent portable oxygen concentrators, and Medicare will often cover part of the cost. *Inogen is a company frequently used for portable oxygen concentrator rental and purchases. You can find them online at **try.inogen.com or by calling 1 877-380-4857** *It is also advised to check with your local medical supply store**

****Please ensure you have adequate oxygen/batteries for 24 hours in order to plan for any unforeseen flight delays/ cancellations****

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, 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 an **ostomy 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, PLEASE discuss this issue with your private physician.

Additional Medical 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 or complications resulting from a medical event while participating in the ***Honor Flight*** program.

SIGNED: _____

DATE: _____/_____/_____

Please mail or email this form to:

Honor Flight Long Island
C/O Jamie Bowden
Department of Community Services
Southampton Town Hall
116 Hampton Road
Southampton, NY 11968
jbowden@southamptontownny.gov
(631) 702-2423
www.honorflightlongisland.org

NOTE: We will not call you **until** it's your turn to fly; however, you are invited to call us anytime.