

# VETERANS HONOR FLIGHT

Application—Please Print & Return Both Pages

YOUR NAME \_\_\_\_\_ NICK NAME \_\_\_\_\_

(First, Middle, Last name as shown on Driver's License or ID)

ADDRESS \_\_\_\_\_ Spouse \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Best Phone \_\_\_\_\_

Email \_\_\_\_\_ Date of Birth \_\_\_\_\_

Equipment used: Cane \_\_\_\_\_ Walker \_\_\_\_\_ Wheelchair \_\_\_\_\_ Scooter \_\_\_\_\_ Other \_\_\_\_\_

Shirt Size: Small \_\_\_\_\_ Medium \_\_\_\_\_ Large \_\_\_\_\_ X-Large \_\_\_\_\_ XX-Large \_\_\_\_\_ XXX-Large \_\_\_\_\_

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Service History: Branch of Service \_\_\_\_\_ Rank \_\_\_\_\_ Include copy of DD214 \_\_\_\_\_

Years of Activity and where served: \_\_\_\_\_

Emergency Contact Information (Someone available the day you travel)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_

**Please review carefully and sign**

I acknowledge and agree that:

1. Photographic & video equipment may be used to memorialize and document the trip and your image may consequently appear in a public forum to promote or advance this cause. I hereby release the photographer and anyone associated with the Honor Flight from all claims and liability relating to said photographs. I hereby give permission for my images captured during this trip and related activities to be used for promotional materials and productions and waive any right or compensation or ownership there to.
2. I further state that medical insurance is my responsibility and I understand that no one individual or organization associated with the trip provides medical care. I also understand that I accept all risks associated with travel and will not hold Honor Flight, Central Iowa Honor Flight or any person or organization 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 by Veteran \_\_\_\_\_ Date \_\_\_\_\_

**Application will not be accepted without medical information on 2<sup>nd</sup> page**

**Central Iowa Honor Flight**

**P.O. Box 125**

**Council Bluffs, Iowa 51502-0125**

**Veterans Honor Flight Application**

Veteran name \_\_\_\_\_

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Medical information will NOT disqualify you. It permits us to assess the support we need during the trip. We **strongly advise** you to discuss this trip with your personal doctor! This information is for our personnel only.

Do you have a problem walking the length of a football field without assistance? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have breathing problems? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please describe \_\_\_\_\_

Do you use a home nebulizer? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please discuss the use of a hand held nebulizer on this trip with your doctor.

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 trip. Your prescription must be turned in with this application.

Do you have any drug allergies? \_\_\_\_\_

Do you have any history of seizures? Yes \_\_\_\_\_ No \_\_\_\_\_ if so, please describe what type \_\_\_\_\_

When was the last seizure? \_\_\_\_\_ If within the last five years you are **strongly** advised to discuss this trip with your physician.

Do you have any problems with motion sickness? Yes \_\_\_\_\_ No \_\_\_\_\_ is it controlled with medications? Yes \_\_\_\_\_

If motion sickness is controlled with medication it is strongly advised you discuss this trip with your doctor.

Do you have a history of open head injuries, sinus or ear problems? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, have you flown since this problem occurred? Yes \_\_\_\_\_ No \_\_\_\_\_. It is strongly advised that you discuss this trip with your private doctor. If you have never flown since these problems please discuss this trip with your doctor Yes \_\_\_\_\_ .

Do you have a urostomy or colostomy bag? Yes \_\_\_\_\_ No \_\_\_\_\_. If yes please make sure the bag is vented prior to the flight. Please discuss this with your doctor.

Additional concerns or comments:

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Please list all medications:

Medication	How often taken	Medication	How often taken
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If you need more space , please attach the list on an additional sheet of paper

Signed by Veteran \_\_\_\_\_ Date \_\_\_\_\_