

Twin Tiers Honor Flight - Veteran Application



YOU MUST COMPLETE ALL REQUIRED FIELDS MARKED WITH ASTERISK (*)

VETERAN INFORMATION

* First Name _____ Middle Name _____ * Last Name _____

Nickname (*leave blank if none*) _____ * DOB ____/____/____ * Gender: Male Female

CONTACT INFORMATION

* Street Address _____

* City _____ * State _____ * Zip code _____

County _____

* Daytime Phone ____-____-____ Evening Phone ____-____-____ Mobile Phone ____-____-____

Email address: _____

SERVICE HISTORY

* Branch of Service (*check all that apply*)

- Army
- Navy
- Air Force
- Marines
- Coast Guard
- Other

* Conflicts during your service (*check all that apply*)

- WWII (Dec. 7, 1941 - Dec. 31, 1946)
- Korea (Jun. 29, 1950 - Jan. 31, 1955)
- Vietnam (Nov. 1, 1955 - May 15, 1975)
- Lebanon/Grenada (Aug. 24, 1982 - Dec. 15, 1983)
- Panama (Dec. 20, 1989 - Feb. 13, 1990)
- Gulf War / War on Terrorism (Aug. 2, 1990 - Present)
- Other Dates

* Service Dates/Comments

* Rank: _____

Hometown: _____

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* Activity during your service period including Duty Assignments

* Form and type of discharge received from the military (if applicable)

EMERGENCY CONTACT

The Emergency Contact should be someone available on the day of the trip.

* First Name _____ * Last Name _____ * Relationship _____

* Street Address _____

* City _____ * State _____ * Zip code _____

* Daytime Phone ____ - ____ - ____ Evening Phone ____ - ____ - ____ Mobile Phone ____ - ____ - ____

Email address _____

ALTERNATE CONTACT

* First Name _____ * Last Name _____ * Relationship _____

* Street Address _____

* City _____ * State _____ * Zip code _____

* Daytime Phone ____ - ____ - ____ Evening Phone ____ - ____ - ____ Mobile Phone ____ - ____ - ____

Email address _____

MEDICAL INFORMATION

* What is your Weight? _____ * What is your Height? _____

* Do you use mobility equipment? Cane Scooter Walker Wheelchair Wheelchair (Wide)

* Can you walk up & down a set of eight bus steps without assistance? Yes No

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*** Medications** *(Attach additional sheet if necessary)*

*** Surgeries** *(Attach additional sheet if necessary)*

*** Do you have any drug allergies?** Yes No

If so, describe your drug allergies: _____

*** Do you have any food allergies?** Yes No

If so, describe your food allergies: _____

*** Do you have a history of seizures?** Yes No

If so, describe what type of seizures: _____

When was your last seizure: _____

*** Do you have problems with motion sickness (sea or air)?** Yes No

Is your motion sickness controlled with medications? Yes No

*** Do you have any breathing problems?** Yes No

If so, describe your breathing problems: _____

*** Do you use a home nebulizer machine?** Yes No

*** Do you use oxygen at any time?** Yes No

If so, describe your use of oxygen: _____

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

If so, 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

Have you flown since the open head injury, sinus or ear problems occurred? Yes No

* Are you claustrophobic? Yes No

* Are you visually impaired? Yes No

* Are you deaf or hard of hearing? Yes No

* Do you have a urostomy, colostomy, or urinary catheter? Yes No

Describe: _____

* Have you been diagnosed with memory problems? Yes No

* Do you have Cognition / Sundowning Issues? Yes No

* Do you use Insulin? Yes No

How is your Diabetes controlled? Insulin or Pills

* Do you wear or have a heart pacemaker implanted? Yes No

* Do you have any condition(s) (not mentioned above) or circumstances which might limit your ability to travel with a commercial airline, or could limit your ability to physically participate in this event?

* Do you require a special meal? Yes No

If so, describe special meal requirements: _____

Do you have a Living Will or Advance Directive? Yes No

Do you have Medical Insurance? Yes No

Primary Insurer Company _____

Primary Insurer Policy Number _____

Do you have a Medical Supplementary Insurance Policy? Yes No

Supplemental Insurer Company _____

Supplemental Insurer Policy Number _____

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* Have you been the recipient of a previous Honor Flight trip or visited the WWII, Korean, Marine Corps or Vietnam War Memorials? Yes No

* T-Shirt Size S M L XL XXL XXXL Other: _____

* Jacket Size S M L XL XXL XXXL Other: _____

If you wish to have someone that meets the criteria of a "QUALIFIED GUARDIAN" accompany you, please list their full first, middle, and last name, relationship and contact information: **NOTE: The Guardian MUST submit an application as well.**

*** 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, images of veterans and guardians may appear in the public forum, such as the media or on a website, to acknowledge, promote or advance the work of **Honor Flight**.

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 activities through video, photo, or other media, to be used solely for the purposes of **Honor Flight** promotions and publications, and waive any rights of compensation or ownership thereto.

2. I further acknowledge 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 I may incur while participating in the **Honor Flight** program.

SIGNED: _____ DATE: ____/____/____

Please submit completed and signed application to:

**Twin Tiers Honor Flight
Attn: Guardian Application
PO Box 1770
Binghamton, NY 13902**

You may also scan and email your application to: twintiershonorflight@gmail.com

Questions: 1-800-683-5403