



Honor Flight Upstate SC Veteran Application



Honor Flight recognizes American veterans for your sacrifices and achievements by flying you to Washington, DC to see YOUR memorial at **no cost**. Top priority (for which we are currently accepting application only) is given to WW II and terminally ill veterans from **all** wars. In order for **Honor Flight** 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**. For more information, please call (864) 963-5774 or (864) 878-1014.

YOUR NAME: _____ Preferred: _____
Full Name as listed on state-issued I.D. (For Name Tag)

Address: _____

City: _____ **State :** _____ **Zip:** _____

Phone: Day: _____ **Evening:** _____ **Cell Phone:** _____

E-mail Address: _____ **How did you hear about Honor Flight?** _____

Date of Birth: _____ **Height:** _____ **Weight:** _____ **Age:** _____ **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) **Spouses cannot accompany to D.C.**

Name: _____ **Relationship:** _____

Address: _____

Phone: Day: _____ **Evening:** _____ **Mobile:** _____

SERVICE HISTORY | **Dates of Service:** _____ **Branch of Service :** _____

Rank: _____ **Home Town:** (from which city and state did you enter the service?): _____

Are you a World War II veteran? _____ **Have you been to Washington, DC to see the WWII Memorial?** _____

Activity during WWII: _____

MEDICAL: Information provided will **NOT** disqualify you. It permits us to assess the support we need during the trip.

Information is for Honor Flight and Medical Personnel only.

• Name & phone # of your physician: _____

• 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 take **blood thinners or aspirin?** Yes _____ No _____ If Yes, how often? _____

- 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, **strongly** advised you discuss trip with your private physician.
- Do you have problems with **motion sickness**? **Yes No**. If yes, controlled with medication? **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: _____
- 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.
- 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.
- Would 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**. Have you flown without problems since the open head injury, sinus or ear problems occurred? **Yes No**. It is **strongly** advised you discuss the trip with your private physician, let him know you will be flying, if you have had an open head injury, sinus or ear problems.
- 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, it is **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 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 while participating in the **Honor Flight** program.

Signed: _____ Date: ____/____/____
(E-mail applicants will be required to sign prior to actual flight date)

Forms may be mailed, e-mailed or faxed as indicated below:

mail: Honor Flight Upstate
Attn: Veteran Application
P. O. Box 838
Simpsonville, SC 29681

e-mail: vets2dc@charter.net

fax: [\(864\) 963-5774](tel:(864)963-5774)

Visit our website:
www.honorflightupstatedesc.com