

Received: _____ Sent to Database: _____ Interviewed: _____



Honor Flight Southern Nevada Veteran Application and Medical Form

Honor Flight Southern Nevada recognizes America's most senior war veterans for their service and sacrifice by flying them (all-expense-paid trip) to Washington, DC to see their memorials.

As soon as the completed form is received by Honor Flight Southern Nevada via mail, fax or scanned emailed pdf file, and it is confirmed that all pages are complete, it will be reviewed by our team members. Once we have completed the review, you will be placed on a waitlist for the war you served in and you will be contacted when we get to your name. All selections are based on the oldest veteran, date of application, and health. All Honor Flight Southern Nevada missions depart from and return to McCarran International Airport. For further information, please contact us at **702-749-5912** or go online to www.honorflightsouthernnevada.org.

Please <i>complete</i> and submit all pages of this form with required signature(s) as soon as possible to:	Honor Flight Southern Nevada 6720 N. Hualapai Way Suite 145-176 Las Vegas, NV 89149 FAX: 702-749-5933 applications@honorflightsouthernnevada.org
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[INCOMPLETE APPLICATIONS CANNOT BE PROCESSED AND WILL BE RETURNED]

Your name: _____

(As it appears on your government issued ID for airline travel) (If applicable)

Nickname: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Primary phone: _____ Cell phone: _____

Email address: _____ Date of birth (Day/Month/Year): ____/____/____

Weight: _____ Height: _____ Gender: Male Female Age at application: _____

T-shirt size (Please circle your size): S M L XL XXL XXXL

Please Circle: WWII Korean War Vietnam War

How did you hear about Honor Flight Southern Nevada? _____

Dates you served in the military (Month/Year to Month/Year): ____/____ to ____/____

Branch of service: Army Air Force Navy Marines Coast Guard

Other _____ Rank: _____ Service number: (if known) _____

Country(ies) where you served: _____

Activity during the war: _____

Any medals or commendations received during service, any special events:

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CONTACT INFORMATION

Primary emergency contact (someone available the day you travel):

Name: _____

Relationship: _____

Address: _____

City: _____

State: _____ Phone: Day _____ Evening _____

Cell _____ Email: _____

Non-Spouse alternate contact (son, daughter, grandchild, personal friend):

Name: _____

Relationship: _____

Address: _____

City: _____

State: _____ Phone: Day _____ Evening _____

Cell _____ Email: _____

Non-Spouse alternate contact (son, daughter, grandchild, personal friend):

Name: _____

Relationship: _____

Address: _____

City: _____

State: _____ Phone: Day _____ Evening _____

Cell _____ Email: _____

GUARDIAN INFORMATION

Honor Flight Southern Nevada will provide a wheelchair for each Veteran as needed, as well, as an Honor Flight Southern Nevada Guardian. These guardians will accompany and assist you throughout the day to help ensure a safe and memorable experience. If you believe there is a medical need that necessitates a family member be considered to act as your guardian, they must be in good health, and be able to push a 300lbs in a wheelchair for 8 hours and lift 100lbs, if needed. Please list that person's contact information below and ask the family member to complete a guardian application found at www.honorflightsouthernnevada.org as soon as possible.

Guardians must attend a training class and pay a fee that covers a portion of the cost of the three day trip. **Completion of the Guardian Application** combined with your written request below, will assure that your request is considered, however selection is not guaranteed. **Your spouse or significant other is NOT eligible to accompany you on the flight.**

Requested guardian name: _____

Phone: _____ Requested guardian email: _____

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YOUR MEDICAL INFORMATION

1. Place of residence:

Private home Private condo/apartment Independent living/Assisted living/Nursing home

2. Do you have a personal care attendant?

No Yes 8-12 hours 2-4 times per week 24 hours

3. Do you attend adult day care? Yes, how many days per week? _____ No

4. Please check all that apply: Cane Walker Crutches Wheelchair Scooter
 Prosthetics/braces None of the above

5. Can you climb five stairs using handrails with minimal assistance? Yes No

6. How far can you walk without assistance? None 0-10 steps 25 feet One block or more

7a. Have you suffered an injury from a fall in the past six months? Yes No

If yes, please specify _____

7b. Have you been hospitalized or had surgery in the past six months?

(If yes, please list below) Yes No

Reason for Surgery or Hospitalization	Date

8. Do you have diabetes? Yes No

If yes, how do you control it? Insulin Pill Diet controlled

9. Do you have a pacemaker/defibrillator? Yes No

Do you have a history of heart problems? Yes No

If yes, please specify: _____

10. History of COPD or asthma? Yes No If yes, please describe: _____

11. Are you prescribed oxygen by your doctor?

Yes No 24 hours As needed With sleep apnea mask

Night time only (not related to sleep apnea)

If yes, your private physician must write a prescription for oxygen to be used during the flight and/or day. HFSN can only supply oxygen concentrators at the hotel. You must have supply the oxygen machine needed on the flight.

12. Do you need nebulizer treatments or use an inhaler? Yes No If yes, how often? _____

13. Any history of heat exhaustion or difficulty breathing in the heat? Yes No

14. Do you have a history of high blood pressure or on medication for it? Yes No

15. Do you have any history of visual impairment (other than glasses)? Yes No

If yes, please describe: _____

16. History of neurological problems (i.e., stroke, Parkinson's disease)? Yes No

If yes, please describe: _____

17. History of seizures or taking seizure medications? Yes No

If yes, please list type of seizure: (i.e., grand mal, petit mal, other) _____

When was your last seizure? _____

18. Do you have problems with motion sickness? Yes No

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19. History of Dementia or Alzheimer's OR are you on prescription medications for memory?

Yes No

20. Do you use incontinence pads? Bladder: Yes No Bowel: Yes No

Are you able to change: Independently With minimal assistance

With stand-by assistance Does someone provide this care for you? Yes No

21. Do you have a foley, urostomy, or colostomy bag? Yes No

22. Are you currently undergoing dialysis? Yes No

23. Do you smoke? Yes No

24. Are you claustrophobic? Yes No Are you able to take a 5-hour plane ride? _____

25. Please list any allergies you have: _____

Any bee sting reaction? Yes No Do you carry an epinephrine pen with you? Yes No

If yes, please bring your epinephrine pen with you on the trip. Initial here: _____

26. Other medical or health concerns not previously disclosed: **MUST BE COMPLETED**

MEDICATIONS (List or attach a separate sheet)

THIS MUST BE COMPLETED TO PREVENT YOUR APPLICATION FROM BEING RETURNED. IF NO MEDICATIONS, PLEASE INDICATE N/A.

Name of Medication	Dose	When Taken

DAY OF THE FLIGHT - PLEASE BRING A SUPPLY OF YOUR MEDICATIONS TO LAST 5 DAYS

Physician's name: _____

Physician's phone number: _____ FAX: _____

Date of last exam: _____

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MEDICAL RELEASE

The information I have provided is complete and accurate. I understand that Honor Flight Southern Nevada medical volunteers will review my health history and may speak with my healthcare provider(s) to clarify any medical concerns. Honor Flight Southern Nevada must medically approve all participants to fly. I agree to notify Honor Flight Southern Nevada immediately should my medical condition change prior to the trip. If any of this information is **falsified or pertinent medical information is omitted**, or if my medical conditions change or are determined by Honor Flight Southern Nevada to be unacceptable to participate, I understand I may be disqualified from participating in an Honor Flight at the sole discretion of Honor Flight Southern Nevada. I understand that medical insurance and medical costs that may be incurred pursuant to participation are my responsibility and that Honor Flight Southern Nevada does not provide medical care. I understand that I accept all risks associated with travel and other Honor Flight Southern Nevada activities, and that I have executed a Release, Covenant Not to Sue and Indemnity agreement in favor of Honor Flight Southern Nevada while participating in the program. ***I hereby give consent and permission to any of my medical providers or emergency medical providers to discuss and release my health and treatment information for treatment purposes I may require during my participation in the Honor Flight Southern Nevada program and my signature on this page shall be sufficient evidence of my consent.*** My signature authorizes you to call my physician or any other personnel familiar with my care to discuss my medical history. Please note that a facsimile signature will also be accepted as an original signature.

PHOTOGRAPHIC AND MEDIA RELEASE

As photographic and video equipment are frequently used to memorialize and document **Honor Flight Southern Nevada (HFSN) and the Honor Flight Network (HFN)** 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 **HFSN and the HFN** program. I hereby release the photographer and **HFSN and the HFN** from all claims and liability relating to said photographs. I hereby give permission for my images captured during **HFSN and the HFN** activities through video, photo, or other media, to be used solely for the purposes of **HFSN and the HFN** promotional material and publications, and waive any rights of compensation or ownership thereto.

Veteran signature required: _____

Please print your name: _____

Date form completed: _____

If the Veteran was assisted in completion of this form, please sign here and print your name, relationship and phone number:

Please sign your name: _____

Please print your name: _____

Relationship: _____ Phone number: _____