

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. We are currently accepting applications for our WWII veterans, Korean War, and Vietnam Veterans.

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. **Veteran application priority goes to our oldest veterans and then date of application.** All Honor Flight Southern Nevada missions depart from and return to Harry Reid International Airport. For further information, please contact us at **702-749-5912** or go online to www.honorflightsouthernnevada.org.

Please note: HFSN has the right to refuse service to any individual.

Please complete legibly in black ink and submit all pages of this form with required signature(s) to:

1. or	Print the completed form and mail to:	Honor Flight Southern Nevada 6720 N. Hualapai Way Suite 145-176 Las Vegas, NV 89149
2. or	Save the form (Save As), attach it to an email and send to: (This is the preferred method.)	applications@honorflightsouthernnevada.org
3. or	Scan the form and email to	applications@honorflightsouthernnevada.org
4.	Print the form and fax to:	702-749-5933

INCOMPLETE APPLICATIONS CANNOT BE PROCESSED AND WILL BE RETURNED

PLEASE BE AWARE: The Transportation Security Administration is reminding travelers that beginning May 7, 2025, every traveler must present a REAL ID-compliant driver's license, or another acceptable form of identification, to fly within the United States. **Veterans will room with another veteran or with a family member that serves as guardian.**

Your full name: _____
(Name must be as it appears on your government issued ID)

Nickname: _____ (If applicable)

Address: _____

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

Primary phone: _____ Cell phone: _____

Email address: _____

Date of Birth (Day/Month/Year): ____/____/____ Age at application: _____

Weight: _____ Height: _____ Gender: ☐ Male ☐ Female

Shirt size (Please select your size): ☐ S ☐ M ☐ L ☐ XL ☐ 2XL ☐ 3XL

Please have your DD-214 available. You will be asked to show your DD-214 at the time you are interviewed by Honor Flight Southern Nevada Team Member.

Please Circle: WWII (12/7/41- 12/31/46) Korean War (6/27/50 -1/31/55) Vietnam War (11/1/55 – 4/30/75)

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

Branch of service: ☐ Army ☐ Air Force ☐ Navy ☐ Marines ☐ Coast Guard ☐ Merchant Marines

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:

How did you hear about Honor Flight Southern Nevada? _____

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 up to 6 miles a day 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

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: _____

YOUR MEDICAL INFORMATION

PLEASE UNDERSTAND PROVIDING MEDICAL INFORMATION ALLOWS OUR MEDICAL TEAM TO BETTER ASSIST YOU AND DOES NOT AUTOMATICALLY DISQUALIFY YOU FROM PARTICIPATING ON THE FLIGHT.

1. Place of residence: ☐ Private home ☐ Private condo/apartment ☐ Independent living/Assisted living/Nursing home
2. Please check all that apply: ☐ Cane ☐ Walker ☐ Crutches ☐ Wheelchair ☐ Scooter ☐ Prosthetics/braces
3. Can you climb five stairs using handrails with minimal assistance? ☐ Yes ☐ No
4. How far can you walk without assistance? ☐ None ☐ 0-10 steps ☐ 25 feet ☐ One block or more
- 5a. Have you suffered an injury from a fall in the past six months? ☐ Yes ☐ No
- If yes, please specify _____

- 5b. 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

6. Do you have diabetes? ☐ Yes ☐ No If yes, how do you control it? ☐ Insulin ☐ Pill ☐ Diet controlled
7. Do you have a pacemaker/defibrillator? ☐ Yes ☐ No Do you have a history of heart problems? ☐ Yes ☐ No
- If yes, please specify: _____
8. History of COPD (emphysema) or asthma? ☐ Yes ☐ No If yes, please describe: _____
9. 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. You must supply the oxygen machine needed on the flight that meets airline requirements.**
10. Do you need nebulizer treatments or use an inhaler? ☐ Yes ☐ No If yes, how often? _____
11. Do you have a history of high blood pressure or on medication for it? ☐ Yes ☐ No
12. Do you have any history of visual impairment (other than glasses)? ☐ Yes ☐ No
- If yes, please describe: _____
13. History of neurological problems (i.e., stroke, Parkinson's disease)? ☐ Yes ☐ No
- If yes, please describe: _____
14. 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? _____
15. History of Dementia or Alzheimer's OR are you on prescription medications for memory? ☐ Yes ☐ No
16. 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
17. Do you have a foley, urostomy, or colostomy bag? ☐ Yes ☐ No
18. Are you currently undergoing dialysis? ☐ Yes ☐ No
19. Are you claustrophobic? ☐ Yes ☐ No Are you able to take a 5-hour plane ride? _____
20. Please list any allergies you have: _____
- Do you carry an epinephrine pen with you? ☐ Yes ☐ No
- If yes, please bring your epinephrine pen with you on the trip. Initial here: _____
21. Do you have any dietary restrictions? ☐ None ☐ Vegan ☐ Gluten-Free
22. Do you give permission to HFSN Medical staff to follow-up with Physician, if necessary: ☐ Yes ☐ No

23. Do you have a Medical Power of Attorney: ☐ Yes ☐ No

If yes, please provide the following:

Contact Name _____ Contact Phone Number: Name _____

24. 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. VETERAN WILL BE REQUIRED TO SUBMIT A DETAILED MEDICATION LIST AT TIME OF VETERAN SELECTION. VETERAN WILL NEED TO PROVIDE UPDATED MEDICATION LIST AT TIME OF FLIGHT. IF NO MEDICATIONS, PLEASE INDICATE N/A.

Name of Medication	Name of Medication

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

(Clearly print) Primary Physician's name: _____

Physician's phone number (number in case of emergency or RX refill): _____

Specialty Physician (Cardiologist/Pulmonologist/Oncologist ect.) name: _____

Date of last exam: _____

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 will sign 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 or digital 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: _____