

Ellis County Honor Flight Veteran Application

Honor Flight wishes to recognize all American World War II veterans for their service, sacrifices, and achievements by flying them to Washington, DC to see *THEIR* memorial at no cost. Top priority is given to World War 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 further information, please contact us @ (972) 351-1750, (972) 351-5122 or (972) 938-2708 or visit us at www.elliscountyhonorflight.org

*In the future Honor Flight may be extended to include veterans of all conflicts involving American service men & women.

DATE ____/____/____

Date application received by ECHF ____/____/____

NAME: _____ (As it appears on your picture DL/ID for airline travel)

NICK NAME: _____ (If Applicable)

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: Day: _____ Evening: _____ Cell Phone: _____

E-MAIL ADDRESS: _____ WEIGHT: _____ DOB: ____/____/____

WINDBREAKER/JACKET SIZE: (S, M, L, XL, XXL, XXXL) _____

HOW DID YOU HEAR ABOUT HONOR FLIGHT? _____

SERVICE HISTORY: BRANCH OF SERVICE: _____ RANK: _____

HOME TOWN (from which city and state did you enter the service)? _____

ACTIVITY DURING WWII: _____

ALTERNATE CONTACT: _____

PHONE: _____ E-MAIL: _____ RELATIONSHIP: _____

EMERGENCY CONTACT INFORMATION (someone available on the days you travel):

Name: _____ Relationship: _____

Address: _____

PHONE: Day: _____ Evening: _____ Cell: _____

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/Guardian 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)

PLEASE FILL OUT THE MEDICAL QUESTIONNAIRE ON THE NEXT PAGE AND RETURN THIS ENTIRE APPLICATION TO:

**ELLIS COUNTY HONOR FLIGHT
P.O. BOX 35
WAXAHACHIE, TEXAS 75168
ATTN: Melissa Ballard**

**Work: (972) 351-5122
Cell: (972) 351-1750**

EMAIL: mballard@cnbwax.com

MEDICAL INFORMATION PROVIDED WILL NOT DISQUALIFY YOU, BUT IT WILL ALLOW US TO ASSESS THE SUPPORT WE NEED DURING THE TRIP. THIS INFORMATION IS STRICTLY FOR THE USE OF ELLIS COUNTY HONOR FLIGHT AND MEDICAL PERSONNEL ONLY. PLEASE ATTACH A SEPARATE SHEET OF PAPER WITH ANY OTHER INFORMATION YOU THINK MIGHT BE HELPFUL IN THIS ASSESSMENT.

PLEASE COMPLETE THE NEXT SECTION AS ACCURATELY AS POSSIBLE. A PHYSICIAN WILL BE TRAVELING WITH THE ELLIS COUNTY HONOR FLIGHT ORGANIZATION ON THIS TRIP, AND WILL REVIEW ALL INFORMATION PRIOR TO DEPARTURE.

VETERAN NAME: _____

Do you use mobility equipment? YES ____ NO ____

If YES, please circle device: CANE WALKER WHEELCHAIR SCOOTER

MEDICATIONS (name and how often you take it):

MEDICATION TAKEN	HOW OFTEN?	MEDICATION TAKEN	HOW OFTEN?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have any drug allergies? _____

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 (sea or air)? YES ____ NO ____

If yes, is it controlled with medications? 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.

Do 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, ECT) _____

Do you have a history of open head injuries, sinus problems, or ear problems? YES ____ NO ____

If YES, have you flown since the open head injury, sinus or ear problems occurred? YES ____ NO ____

If YES, did you have any problems? YES ____ NO ____

If YES, it is STRONGLY advised you discuss the trip with your private physician. If you have NEVER flown since the open head injury, sinus or ear problems, again we STRONGLY advise you discuss the trip with your private physician.

Do you have a ureterostomy 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:

