



# 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 the future, Honor Flight will be expanded to include Korean and Vietnam veterans. 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 a (937) 521-2400 or visit us at www.honorflight.org

**YOUR NAME:** \_\_\_\_\_ **NICK NAME:** \_\_\_\_\_  
(As it appears on your ID for airline travel) (If Applicable)

**ADDRESS:** \_\_\_\_\_

**CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_

**PHONE: Day:** \_\_\_\_\_ **Evening:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**E-MAIL ADDRESS:** \_\_\_\_\_ **WEIGHT:** \_\_\_\_\_ **AGE:** \_\_\_\_\_

**HOW DID YOU HEAR ABOUT HONOR FLIGHT?** \_\_\_\_\_  
\_\_\_\_\_ **TEE 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):**

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**PHONE: Day:** \_\_\_\_\_ **Evening:** \_\_\_\_\_ **Mobile:** \_\_\_\_\_

**SERVICE HISTORY: BRANCH OF SERVICE:** \_\_\_\_\_ **RANK:** \_\_\_\_\_

**HOME TOWN (from which city and state did you enter the service?):** \_\_\_\_\_

**ACTIVITY DURING WWII:** \_\_\_\_\_

**MEDICAL: INFORMATION PROVIDED WILL NOT DISQUALIFY YOU. IT PERMITS US TO ASSESS THE SUPPORT WE NEED DURING THE TRIP. INFO IS FOR HONOR FLIGHT AND MEDICAL PERSONNEL ONLY.**

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!

**PLEASE COMPLETE BACK PAGE**

