FOR KANSAS HONOR FLIGHT USE ONLY: Date Received _____/_____/_____ by _____ Entered ☐ by _____

KANSAS HONOR FLIGHT, INC.

AN OFFICIAL HONOR FLIGHT NETWORK HUB
P.O. Box 2371 – Hutchinson, KS 67504-2371 – PHONE: 620-546-2400

Veteran Application

Kansas Honor Flight, Inc. (Honor Flight) recognizes American Veterans for your sacrifices and achievements by flying you to Washington, D.C. to see your Memorial at no cost to the veteran. Priority is given to terminally ill Veterans who qualify. Veteran selection is by war (WW II, Korean War, and Vietnam War) and then by the date the application is received by Kansas Honor Flight, unless other circumstances prevail. Kansas Honor Flight strives to provide a safe and comfortable trip for the veterans. Guardians will accompany those Veterans needing physical assistance to have a safe, memorable and rewarding experience. For additional information, please contact us by phone at (620) 546-2400 or by e-mail at Info@KansasHonorFlight.org or visit our website at www.KansasHonorFlight.org.

YOUR INFORMATION (please copy this information from your driver's license or state-issued ID)			
FIRST	MIDDLE	LAST	
NAME TO BE USED ON NAME TAG			
ADDRESS			
CITY		STATE	ZIP
PHONE DAY		EVENING	CELL
EMAIL ADDRESS			
WEIGHT lbs	BIRTHDAY Month/Day/Year	AGE	GENDER
T-SHIRT SIZE (Circle One) M – L – XL - 2XL - 3XL			

SERVICE HISTORY			
CIRCLE ONE	World War II	Korean War	Vietnam War
Date of Service: From:	To:	*(May be subject to verification)*	
Branch of Service		Rank at discharge?	
Where did you serve?			
Activity during the War?			

VETERANS FLYING TOGETHER If you wish to experience your trip to Washington, D.C. with another veteran who served during the same era, please list his/her name and phone number. He/she must also submit a Veteran Application which can be downloaded from our web site or we will mail them the form. If possible, submit all applications together to help in your request. Kansas Honor Flight will do its best, but makes no guarantee that the veteran's request will be honored.

Veterans Name (First and Last)	Phone

For those veterans needing physical assistance, the veteran may request a family member (son, daughter, grandson, etc.) or friend to accompany them. The spouse of the veteran may NOT serve as the guardian. **Guardians must be able-bodied** between the ages of 18 & 70. If a family member/friend is not available, one will be provided. All guardians must submit a Guardian Application that is available on our web site or can be requested. All guardians will make a contribution to cover their travel expenses.

Guardian's Name (First & Last)	Phone

(CONTINUE TO PAGE 2)

Veteran's Name:		
Alternate Contact (Spouse, son, daughter, friend, neighbor, etc. – PLEASE CIRCLE ONE)		
FIRST	MIDDLE	LAST
NICK NAME (if applicable)		GENDER
ADDRESS		
CITY	STATE	ZIP
PHONE Day	Evening	Cell
EMAIL ADDRESS (if applicable)		

Emergency Contact (someone available the day of the trip.)		
FIRST	MIDDLE	LAST
PHONE	Cell	RELATIONSHIP
EMAIL ADDRESS (if applicable)		

**** * * 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 and or 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 hereto.

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 Kansas Honor Flight, Inc. or Honor Flight, Inc. responsible for any injuries incurred by me while participating in the Honor Flight program.

SIGNED: _____ DATE: _____/_____/_____
(E-mail and fax applicants will be required to sign prior to actual flight date) Month Day Year

Mail this Veteran Application to:

Kansas Honor Flight, Inc.
P.O. Box 2371
Hutchinson, KS 67504-2371

Or, if you prefer you may Email the application to: application@KansasHonorFlight.org

Contact us by phone if you have any questions at **620-546-2400**

All programs and services of Kansas Honor Flight, Inc. are offered on a non-discriminatory basis, without regard to race, color, national origin, religion, sex, sexual orientation, age, marital or family status, disability or political beliefs.

(CONTINUE TO PAGE 3)

Veteran's Name:

This information permits assessment of support services needed during your trip. Information is for volunteer medical, flight and administrative staff only. Talk to your doctor about this trip!!!

	Yes	No	If yes, to ANY question, it is **STRONGLY** advised that you discuss the trip with your physician!
Do you have a pacemaker?			
Do you use mobility equipment?			If yes, please check type of device(s) ___ Cane ___ Wheelchair ___Wheelchair confined? ___ Walker ___ Scooter ___ Other
Do you have problems with motion sickness?			If yes, is it controlled with medications?
Would it be difficult for you to walk the length of a football field unassisted?			If yes, please describe (e.g., heart/lung problems, arthritis, etc.)
Do you have balance issues or problems with being dizzy?			If yes, please describe…
Do you have diabetes?			If yes, do you take diabetes medication? _____ If yes, Injected____ Oral_____ If yes, how often?_____.
Do you have any dietary requirements?			If yes, please describe (e.g., vegetarian, gluten free, etc.) _____.
Do you have a urostomy or colostomy bag?			If yes, please specify. Please make sure the bag is vented prior to flight. Are you incontinent? If yes, please describe.
Do you have a history of seizures? (e.g., grand mal, petit mal, other)			If yes, please describe If yes, when was your last seizure?
Do you have any breathing problems?			If yes, please describe
Do you use oxygen at any time?			If yes, when do you use it? _____. Your private physician must write a prescription for oxygen to be used during the trip. Honor Flight will provide the oxygen.
Do you use a home nebulizer machine?			If yes, will you be able to use portable, hand-held nebulizers during the trip?
Do you use a CPAP?			
Do you have a history of open head injuries?			If yes, to open head injury, sinus or ear problems please answer the following: • Have you flown since the problem occurred? _____ • If you have flown, did you have any problems? _____ • If there were problems, please describe…
Do you have a history of sins problems?			
Do you have a history of ear problems?			
Sinus problems?			
Ear problems?			
Do you have any drug allergies?			If yes, please list

Additional health concerns you may have that Honor Flight should be aware of (Please describe)

PRIORITY TRAVEL REQUESTED (ONLY for the terminally ill of qualifying wars) If priority travel is indicated, please also contact our office at 620-546-2400). It is STRONGLY advised that you discuss the trip with your physician!

PRESCRIPTION MEDICATIONS (continue on page 4)

(CONTINUE TO PAGE 4)

PRESCRIPTION MEDICATION: PRESCRIPTION MEDICATIONS (continued from page 3)

MEDICATION NAME:		TIME OF DAY:	AM PM	QUANTITY:	
Reason Medication Taken & Other Remarks:					
MEDICATION NAME:		TIME OF DAY:	AM PM	QUANTITY:	
Reason Medication Taken & Other Remarks:					
MEDICATION NAME:		TIME OF DAY:	AM PM	QUANTITY:	
Reason Medication Taken & Other Remarks:					
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Reason Medication Taken & Other Remarks:					
MEDICATION NAME:		TIME OF DAY:	AM PM	QUANTITY:	
Reason Medication Taken & Other Remarks:					

IF YOU HAVE MORE MEDICATIONS, PLEASE LIST ON A 8.5 X 11 SHEET OF PAPER ADD ATTACH TO APPLICATION

Your signature on this page grants us the right to share your information with our volunteer medical, flight and administrative staff.

Signature:______________________________ Date: ______________