



FOR HONOR FLIGHT USE ONLY: LN: _____ DR: _____

Land of Lincoln Honor Flight 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 at (314) 427-2317 or (217) 622-1473 or visit us at: <http://www.landoflincolnhonorflight.org>

YOUR NAME: _____ NICK NAME: _____
(as it appears on your photo ID or driver's license) (if applicable)

ADDRESS: _____

CITY: _____ COUNTY: _____ ZIP: _____

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

E-MAIL ADDRESS (if you check your email): _____

GENDER _____ WEIGHT _____ AGE: _____ DATE OF BIRTH: _____

TEE SHIRT SIZE: ___ S ___ M ___ L ___ XL ___ XXL ___ XXXL

EMERGENCY CONTACT INFORMATION (this person must be available the day you travel):

Name: _____ Relationship: _____

Address: _____ City/State/Zip _____

PHONE: Day: _____ Evening: _____ Cell: _____

ALTERNATE CONTACT – NOT A SPOUSE (Can be a son, daughter, grandchild, good friend, etc):

Name: _____ Relationship: _____

PHONE: Day: _____ Evening: _____ Cell: _____

Is there another veteran you would like to fly with? If so, who? Please make sure that they submit an application.

Is there a person who you would like to be your guardian (Spouses can't be guardians: Minimum age: 18)? If so, who? Their phone number? Please make sure they submit a guardian application. If you don't have a guardian request, we have trained people who have volunteered to be guardians and would be happy to assist you.

(Every effort will be made to comply with your requests, but we cannot guarantee this will happen.)

During which time period(s) did you serve?

SERVICE HISTORY: BRANCH: _____ **RANK:** _____

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

NEXT PAGE (OVER)

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.

Please check which apply and explain as requested:

- _____ 1. I am diabetic which is controlled by ___Diet ___Oral medication ___Insulin
- _____ 2. I use the following mobility equipment: ___Cane ___Walker ___Wheelchair ___Scooter
- _____ 3. I will need to use a wheelchair all of the time during the trip.
- _____ 4. I am allergic to (list drugs, foods, etc.):
- _____ 5. I have breathing problems. Explain:
- _____ 6. I have a history of seizures. Give date and type of last seizure:
If within past 5 years, discuss the trip with your doctor.
- _____ 7. I have experienced motion sickness (sea or air). If YES, check one: It ___is ___is not controlled with medications. If not controlled with medications, discuss the trip with your doctor.
- _____ 8. I use a home nebulizer machine. If YES, ask your doctor about the use of a portable hand-held nebulizer during the trip.
- _____ 9. I use oxygen ONLY at night.
- _____ 10. I will need to use oxygen on flight day. If YES, ask for prescription and concentrator requirements. Oxygen will be provided in DC.
- _____ 11. I have a history of open head injuries, sinus problems, or ear problems?
If YES, have you flown since any of these problems occurred?
If YES, did you have any problems?
If YES or you have not flown since the problem, discuss the trip with your doctor.
- _____ 12. I have a ___urostomy or ___colostomy or ___ileostomy bag. If YES, please make sure the bag is vented prior to flight. If you do not know if your bag is vented, discuss this issue with your doctor.

13. Please list or attach medication information.

MEDICATION	TAKEN HOW OFTEN?	MEDICATION	TAKEN HOW OFTEN?
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_____	_____	_____	_____
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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 and I understand that neither Honor Flight nor the provider of free private aircraft ("Flight Provider") provides medical care. I understand that I accept all risks associated with travel and other Honor Flight Network activities and will not hold Honor Flight, the Flight Provider, or any person appearing or quoted in any advertisement or public service announcement for or on behalf of Honor Flight responsible for any injuries incurred by me while participating in the Honor Flight program.

SIGNED: _____ DATE: ___/___/___

Please submit this form to: Land of Lincoln Honor Flight, Inc. Attn: Ray Wiedle
10912 St. Francis Lane St. Ann, MO 63074