



VETERAN APPLICATION – Vietnam Era

These are the dates set by congress for the Vietnam War. **Applicants must have served during these dates to be considered a Vietnam War Era Veteran: February 28, 1961 – May 7, 1975**

Honor Flight Network recognizes the American veteran for your sacrifices and achievements by flying you to Washington, DC to see YOUR memorial and others at no cost. Top priority however continues to be for WWII Veterans, followed by Korean Veterans and terminally ill veterans from all wars. *For Honor Flight to achieve this goal a Guardian will be assigned to provide assistance in helping you and the other veterans have a safe, memorable, and rewarding experience.* For all you and your comrades have sacrificed for us, please consider this a small token of appreciation from all of us at Honor Flight. For Honor Flight of the Quad Cities information, please check our website at www.HonorFlightQC.org or call us at (563) 388-3592. **Thank You for your service.**

YOUR NAME: _____ NICK NAME: _____
 Please Print First Full Middle Last (If used)

ADDRESS: _____

CITY: _____ COUNTY: _____ STATE: _____ ZIP: _____

PHONE: DAY: _____ EVENING: _____ MOBILE _____

E-MAIL: _____ WEIGHT: _____ AGE _____ BIRTH DATE (M/D/Y): _____

GENDER (M, F) _____ TEE SHIRT SIZE: (S, M, L, XL, XXL, XXXL) _____

EMERGENCY CONTACT INFORMATION (someone available the day you travel):

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____

PHONE: DAY: _____ EVENING: _____ MOBILE: _____

ALTERNATE CONTACT (SON, DAUGHTER, ETC): NAME _____

PHONE: _____ E-MAIL: _____ RELATIONSHIP: _____

SERVICE HISTORY: BRANCH OF SERVICE: _____ RANK: _____

LIST DATES OF SERVICE: _____

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.

MEDICATIONS (name and how often you take it):

<u>MEDICATION</u>	<u>TAKEN HOW OFTEN</u>	<u>MEDICATION</u>	<u>TAKEN HOW OFTEN</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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) _____

Date of last seizure. _____. If within past 5 years, **STRONGLY** advised you discuss trip with your private physician!

PLEASE COMPLETE and SIGN THE BACK PAGE!

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, etc.): _____

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 **urostomy 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:

PLEASE REVIEW CAREFULLY AND SIGN: (*Honor Flight refers to Honor Flight of the Quad Cities and Honor Flight Network*)

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 **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 injury/illness incurred by me while participating in the **Honor Flight** program.
3. **I understand that Honor Flight of the Quad Cities has a Guardian for me, and is not accepting additional Guardian applications at this time.**

SIGNED: _____ DATE: ____/____/____

(E-mail applicants will be required to sign prior to actual flight date)

Please submit this form to:



**Honor Flight of the Quad Cities
c/o Ridgecrest Village
4130 Northwest Blvd.
Davenport, IA 52806**

Or fax to: (563) 388-3287