



VETERAN APPLICATION

Honor Flight Columbus recognizes veterans for their sacrifices and achievements by flying them to Washington, D.C. to see their memorials, at **no cost**. *Currently, we are accepting applications from World War II and Korean veterans, and terminally ill veterans from all wars.* **Honor Flight Columbus** supplies “guardians” who provide assistance and support as needed. **Honor Flight Columbus** provides this trip to our nation’s veterans in gratitude for their service and sacrifice.

YOUR NAME (please copy this information from your driver’s license or state-issued ID)							
FIRST		MIDDLE			LAST		
NICK NAME (if applicable)					GENDER Male <input type="checkbox"/> Female <input type="checkbox"/>		
WEIGHT		BIRTHDAY Month/Day/Year				AGE	
TEE SHIRT SIZE (mark with “X”)		S	M	L	XL	2X	3X
ADDRESS							
CITY			STATE			ZIP	
PHONE		Day		Evening		Cell	
EMAIL ADDRESS (if available)							
HOW DID YOU HEAR ABOUT HONOR FLIGHT?							

SERVICE HISTORY

Hometown (when you entered the service)		City	State
Branch of Service (mark with “X”)	Army	Navy	Marines
	Army Air Corp	Coast Guard	Merchant Marines
Time of service (mark with “X”)	WWII	KOREAN	OTHER
Dates of Service (as much as is known) From _____ To _____			Rank
Where Did You Serve?			
Activity during the War			

FRIENDS FLYING TOGETHER

If you wish to experience your trip to Washington, D.C. with a friend who is a WWII or Korean veteran, please list his/her name and phone number. Your WWII or Korean buddy must also submit an application. We suggest submitting your applications together to help us match up the forms.

Friend’s Name (First and Last)	Friend’s Phone Number

CONTACT INFORMATION

Spouse Contact (if applicable)	
Name	Cell Phone (if available)
Family or Friend Contact (someone at a <i>different</i> phone number)	
Name	Relationship
Email	Phone
Emergency Contact (Someone available the day you travel)	
Name	Relationship
Phone	Cell Phone (if available)

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 Columbus** trips and events, my 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 Columbus** program. I hereby release all media creators and **Honor Flight Columbus** from all claims and liability relating to said media. I hereby give permission for my images captured during **Honor Flight Columbus** activities through video, photo, or other media, to be used solely for the purposes of **Honor Flight Columbus** promotional material and publications and waive any rights of compensation or ownership thereto.
2. I further state that medical insurance is the responsibility of the veteran and I understand that **Honor Flight Columbus 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 Columbus** responsible for any injuries incurred by me while participating in the **Honor Flight Columbus** program.

Signature _____ Date _____

Please fill out the medical information on the next page and include it with your application. We must have all pages. Thank you!

Please mail all pages of this application to:

Honor Flight Columbus
ATTN: Veteran Application
2185 Ridgecliff Road
Columbus, OH 43221

Or e-mail application to: Columbus@HonorFlight.org

For questions or further information, please contact us at **614-284-4987**,
by email at Columbus@HonorFlight.org,
or visit the **Honor Flight Columbus** website at www.HonorFlightColumbus.org

Your Name _____
 (First) (Middle) (Last)

MEDICAL INFORMATION: So that we may assist you as appropriate, please provide the following information. This permits us to assess the support we need to provide during the trip. Information is for Honor Flight Columbus and volunteer personnel only. Your signature on this page grants us the right to share your information with our volunteer medical, flight and administrative staff.

	Yes	No	If yes,
Do you use mobility equipment?			Please check the device Cane <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair <input type="checkbox"/> Scooter <input type="checkbox"/>
Would it be difficult for you to walk the length of a football field unassisted?			Please describe the reason (e.g., lung problems, arthritis, heart problems, etc)
Do you have diabetes?			Do you take diabetes medication? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, injected <input type="checkbox"/> or oral <input type="checkbox"/> ?
Do you have a urostomy or colostomy bag?			Please specify
Do you have a history of seizures? (e.g., grand mal, petit mal, other)			Please describe When was your last seizure? _____
Do you have any breathing problems?			Please describe
Do you use a home nebulizer machine?			If yes, will you be able to use portable, hand-held nebulizers during the trip? Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you use oxygen at any time?			If yes, do you use it ALWAYS? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, do you use it at NIGHT ONLY? Yes <input type="checkbox"/> No <input type="checkbox"/> Your private physician must write a prescription for oxygen to be used during the trip. We will provide the oxygen.
Do you have a history of open head injuries, sinus problems, or ear problems? (circle which ones, if any)			Have you flown since the problem occurred? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, did you have any problems? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please describe
Do you have any drug allergies ?			Please list
Additional health concerns (Please describe)			

MEDICATIONS

Medication Taken	Time of Day

Medication Taken	Time of Day

Signature _____ Date: _____