



Honor Flight Connecticut
A Hub of the National Honor Flight Network

VETERAN APPLICATION

For Honor Flight Connecticut Use Only:

Last Name: _____ **Date Received:** _____

Honor Flight Connecticut, a hub of the National Honor Flight Network, recognizes American Veterans for their sacrifices and achievements by flying you to Washington, DC to see YOUR memorial at no cost. Top priority is given to WW II Veterans. Korean War Veterans, Vietnam Veterans and terminally ill Veterans from all wars. Veterans are taken on a first come first served basis. For what you and your comrades have given to us, please accept this as a small token of appreciation from all of us at Honor Flight Connecticut. Guardians fly with the Veterans on every flight providing assistance and helping Veterans have a safe, memorable and rewarding experience. Please Note: Veterans are eligible only once for this Honor Flight experience.

Please Note: A guardian fee of \$350.00 to cover the cost of travel and meals will be assessed. Guardians must complete a Guardian Application Form, available on the Honor Flight Connecticut website.

Your Information: Name Must Be as it Appears on your ID For Airline Travel (License, Passport, Govt Id)

First _____ Middle _____ Last _____

Nickname to use on Name Tag _____

Address _____

City _____ State _____ Zip _____ County _____

Phone Day _____ Evening _____ Cell _____

Email Address _____

Weight Lbs _____ Birthday Month/Day/Year _____ Age _____ Gender _____

T-Shirt Size (Check One) S M L XL 2XL 3XL

Service History

World War II Korean War Vietnam War Other _____

Date Of Service: From: _____ To: _____ (Attach DD214 Form if available)

Branch Of Service: Air Force Army Coast Guard Marines
 Merchant Marines Navy

Tell us about your time... Medals, ships, planes and battles (use back of sheet if needed)

Rank At Discharge? _____

Where Did You Serve? _____

Activity During The War? _____

***GUARDIAN** 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 and ideally, one generation removed. 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. A guardian fee will be assessed and MUST be paid one (1) week before the flight. Check or credit card accepted.

Guardian's Name (First & Last)	Phone
Address	Cell
	DOB

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. Connecticut Honor Flight will do its best, but makes no guarantee that the veteran's request will be honored.

Veterans Name (First and Last)	Phone
--------------------------------	-------

Alternate Contact Information Provide 2 names that can be contacted now and on travel day

First _____ Middle _____ Last _____

Address _____

City _____ State _____ Zip _____

Phone Day _____ Evening _____ Cell _____

Email Address _____ Relationship _____

First _____ Middle _____ Last _____

Address _____

City _____ State _____ Zip _____

Phone Day _____ Evening _____ Cell _____

Email Address _____ Relationship _____

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!	Attach additional information on separate sheet if needed
		Do you have a pacemaker and/or defibrillator (AICD)?	
		Do you use mobility equipment?	If yes, please check type of device(s) <input type="checkbox"/> Cane <input type="checkbox"/> Wheelchair <input type="checkbox"/> Wheelchair confined? <input type="checkbox"/> Walker <input type="checkbox"/> Scooter <input type="checkbox"/> Other
		Are you able to walk, ascend, descend tour bus with assistance?	
		Do you have problems with motion sickness?	If yes, is it controlled with medications?
		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? <input type="checkbox"/> 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?
		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 sinus and/or ear problems?	
		Are you a smoker?	
		Do you have any drug or food allergies?	If yes, please list
		Do you have a history of an Irregular heart rate, Atrial fibrillation, Valve replacements, history of blood clots, high blood pressure, Congestive Heart Failure.	If yes, please describe

PRESCRIPTION MEDICATION:

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:					

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

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 Connecticut 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/Honor Flight Connecticut program. I hereby release the photographer and Honor Flight/Honor Flight Connecticut from all claims and liability relating to said photographs. I hereby give permission for my images captured during Honor Flight/Honor Flight Connecticut activities through video, photo, or other media, to be used solely for the purposes of Honor Flight/Honor Flight Connecticut promotional material and publications and waive any rights or compensation or ownership thereto.
- 2 I further understand that Honor Flight/Honor Flight Connecticut does not provide medical care. I understand that I accept any risks associated with travel and other Honor Flight activities and will not hold Honor Flight/Honor Flight Connecticut responsible for any injuries incurred by me while participating in the Honor Flight/Honor Flight Connecticut program.
- 3 Your signature on this page grants us the right to share your information with our volunteer medical, flight and administrative staff.
4. I authorize Honor Flight Connecticut officials to release my contact information (home phone and address) to other requesting individuals in the same flight for purposes of communication and camaraderie with the other participants.

NAME PRINTED _____ SIGNED _____

DATE: _____



Please submit this form to:
 Honor Flight Connecticut
 c/o Matt Sparks
 27 Twin Oak Trail
 Beacon Falls, CT 06403