



## -Purple Heart Flight -

### Honor Flight Austin Application and Pre-Flight Checklist

Honor Flight Austin is dedicated to honoring and serving our Veterans from WWII, Korean War and Vietnam War who received a Purple Heart during their service with an all-expense paid trip to Washington D.C. This is our way to say “Thank you” for serving our country and for the sacrifices you made to keep our country safe and free to this day.

- We are taking Veterans from all 3 wars with a Purple heart
- who reside in the 14 surrounding counties of Austin. (Bastrop, Bell, Blanco, Burnet, Caldwell, Fayette, Gillespie, Gonzales, Hays, Lee, Llano, Milam, Travis, Williamson)
- **The Korean Service medal / Vietnam Service Medal is required to participate on this flight. Please submit a copy of your DD-214 with your social # blacked out.**
- This flight is scheduled for June 5-6, 2015, and Veterans will be selected for this flight on a first come first serve basis.
- Once you have been selected to join us on a flight, you will be contacted 1-2 months prior to the departure date. (Please note that there may be changes on the flight and you may be called at a last minute’s notice if you could join or not).
- We fly on Southwest with other passengers

- We travel with our medical staff to ensure your safety and they will be able to respond to any emergencies. Licensed/Active EMS personnel are traveling with us on this flight in uniform.
- This is an overnight trip and will be returning the next night after departing. You will be rooming with another Veteran or assigned guardian depending on any special medical issues we notice on your application. If you request to be with a Veteran friend/family member on the same flight, please indicate this on the application.
- If you are unable to walk at all and requesting a full lift and carry at all time and wheelchair lift on a bus, please indicate this need on the application.
- If you can, please send us a copy of a photo of yourself during your service.

Please submit applications and any other paperwork to the following address

**Honor Flight Austin**

ATTN: Purple Heart Application  
815 A-Brazos St, UPS Box 498  
Austin, Texas, 78701

Email: [Tina.lee@honorflightaustin.org](mailto:Tina.lee@honorflightaustin.org)

Please contact Tina Lee, Director of Administration at 512-974-3306 or by email if you have any questions at all.

We look forward to meeting you and Thank you for your service!

**FOR HONOR FLIGHT AUSTIN USE ONLY**



DATE RECEIVED \_\_\_\_\_ LAST NAME \_\_\_\_\_

## Honor Flight Austin Purple Heart Flight Application and Pre-Flight Checklist

Honor Flight Austin recognizes and honors American Veterans for your sacrifices and achievements by flying you to Washington, DC to see YOUR memorial at **NO COST**. Top priority is given to our WWII and terminally ill Veterans from all wars. In order for Honor Flight Austin to achieve this goal, guardians will be with the Veterans on every flight providing assistance and helping Veterans to 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 HFA. For further information, please contact us toll free at 1-888-530-8880 or visit our website at [www.honorflightaustin.org](http://www.honorflightaustin.org).

### **THANK YOU FOR YOUR SERVICE!!**

**GENERAL INFORMATION:** *Your name must match **EXACTLY** to the government issued picture I.D. that you plan to use at the airport security checkpoints.*

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Middle name or Initial (If Applicable) \_\_\_\_\_

Nickname (That you would like to be called): \_\_\_\_\_

Date of Birth: Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: 19\_\_\_\_\_

Gender (Male, Female) \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_, Texas, Zip Code \_\_\_\_\_

Phone Numbers: Home (\_\_\_\_\_) \_\_\_\_\_, Cell (\_\_\_\_\_) \_\_\_\_\_

Email (If Applicable ): \_\_\_\_\_

Polo Shirt Size: (Small, Medium, Large, XL, XXL, XXXL) \_\_\_\_\_

### **PLEASE NOTE THAT OUR POLO SIZES RUN BIGGER THAN NORMAL\***

Please check all applicable items that might be a concern during the airport screening process:

Pacemaker or ICD (Please note/circle one)	
Defibrillator	
Metal Implant (Hip, knee joints)	
Insulin pump and/or Insulin loading dispensing products	
Oxygen and / or respiratory- related equipment	

**MILITARY SERVICE HISTORY: (DD214 REQUIRED)**

Branch of Service: \_\_\_\_\_

Military Rank at Completion of Service: \_\_\_\_\_

Hometown: (from what city and state did you enter the service?) \_\_\_\_\_

Where did you serve? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What was your job or assignment in the military? \_\_\_\_\_

\_\_\_\_\_

Activity during the War (Theatre of Operation, unit, division, battalion, ship, plane, etc):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Years of Military Service: \_\_\_\_\_

Did you receive the Korean/Vietnam Service Medal? Y \_\_\_\_\_ N: \_\_\_\_\_

Personal awards, medals, honors, and/or unit commendations

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**EMERGENCY CONTACTS:** *List two (2) people you would like us to contact in case of an emergency.*

*(If available, please list at least one family member other than your spouse as a contact)*

**1)** Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Phone Numbers: **Home** (\_\_\_\_\_) \_\_\_\_\_, **Cell** (\_\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

**2)** Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Phone Numbers: **Home** (\_\_\_\_\_) \_\_\_\_\_, **Cell** (\_\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

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DATE RECEIVED \_\_\_\_\_ LAST NAME \_\_\_\_\_

**DAILY ACTIVITIES:** *Please check the boxes that apply to you*

**In the past 3 months I have needed help with these activities?**

ACTIVITY	NEVER	SOMETIMES	ALWAYS
Dressing			
Using the bathroom			
Eating			
Taking Medication			
Bathing/Showering			

**In the past 3 months, I have required the need for one or more of the following.**

	NEVER	SOMETIMES	ALWAYS
Cane			
Walker			
Wheelchair			

**In the past 3 months, I have had difficulty or needed assistance with the following activities?**

	NEVER	SOMETIMES	ALWAYS
Standing for 20 minutes			
Walking 3 blocks			
Climbing Steps (Stairs/Bus)			
Moving around the house			
Getting up from a chair			
Getting out of Bed			

**MEDICAL CONDITIONS:**

*Please place a checkmark next to the condition(s) that you currently have or have had in the past 5 years*

Medication Allergies:

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PLEASE CHECK ALL BOXES THAT APPLY TO YOU AND SKIP THE ASSOCIATED QUESTIONS IF IT DOES NOT PERTAIN TO YOU

**1) NUTRITION AND/ OR GI PROBLEMS**

<b>A. Diabetes</b>	Yes:	No:
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Insulin: \_\_\_\_\_ Oral Medication: \_\_\_\_\_ Both: \_\_\_\_\_  
 I monitor my blood sugar myself: Yes: \_\_\_\_\_ No: \_\_\_\_\_

<b>B. Diet/Food restrictions, requirements, or allergies</b>	Yes:	No:
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Please explain \_\_\_\_\_  
 \_\_\_\_\_

<b>C. Urostomy Bag:</b>	<b>Colostomy Bag:</b>
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Do you maintain it/ them by yourself? Yes: \_\_\_\_\_ No: \_\_\_\_\_

**Note: Please make sure your bag is vented prior to the flight. If you do not know if your bag is vented please discuss this with your physician**

**2) NERVOUS SYSTEM PROBLEMS**

<b>A) Dementia</b>	Yes:	No:
<b>B) Alzheimer's</b>	Yes:	No:

**SKIP QUESTIONS IF YOU MARKED NO**

- 1) Are you comfortable in a crowd?** Yes: \_\_\_\_\_ No: \_\_\_\_\_
- 2) Do you participate in activities outside your home?** Yes: \_\_\_\_\_ No: \_\_\_\_\_
- 3) Are you more confused in the evenings?** Yes: \_\_\_\_\_ No: \_\_\_\_\_
- 4) When was the last time you spent the night away from home?** \_\_\_\_\_

Comments: \_\_\_\_\_

<b>C) Stroke</b>	Yes:	No:	If yes, what year?
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If yes, explain any resulting problems \_\_\_\_\_  
 \_\_\_\_\_

<b>D) Parkinson's Disease</b>	Yes:	No:
<b>E) Motion Sickness</b>	Yes:	No:
<b>F) Epilepsy or Seizures?</b>	Yes:	No:

What was the date and type (if known) of your last seizure? \_\_\_\_\_  
 \_\_\_\_\_

Is your motion sickness controlled with medication? Yes: \_\_\_\_\_ No: \_\_\_\_\_

**Note: If your last seizure occurred within the past 5 years, it is STRONGLY advised that you discuss this trip with your physician**

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DATE RECEIVED \_\_\_\_\_ LAST NAME \_\_\_\_\_

**3) EYE, EAR, NOSE, THROAT, HEAD PROBLEMS**

**A) EYES**

1) Infection, inflammation, other problems	Yes:	No:
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Please explain: \_\_\_\_\_

Please select the following box of which eye(s) sight is lost.

Right Eye	Percentage Loss:
Left Eye	Percentage Loss:

**B) EARS**

1) Infection, inflammation, other problems	Yes:	No:
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Do you experience any issues with your ears during a flight? Yes: \_\_\_\_\_ No: \_\_\_\_\_

Please explain any issues: \_\_\_\_\_

Please select the following box of which ear(s) hearing is lost

Right Ear	Percentage Loss:
Left Ear	Percentage Loss:

2) Any problems with imbalance and/or dizziness?	Yes:	No:
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Please explain: \_\_\_\_\_

**C) NOSE AND SINUSES**

Infection, inflammation, allergies?	Yes:	No:
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Please explain: \_\_\_\_\_

**D) THROAT**

Any difficulty swallowing?	Yes:	No:
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Please explain: \_\_\_\_\_

Do you have a history of an open or closed head injury? Yes: \_\_\_\_\_ No: \_\_\_\_\_

Please explain along with any issues you experienced: \_\_\_\_\_

**Note: Talk to your doctor if you feel that there may be a concern about flying**

**4) HEART/ VASCULAR PROBLEMS**

1) Heart Attack?	Yes:	If yes, what year(s)
2) Chest Pain?	Yes:	No:
If yes, is it controlled with medication?	Yes:	No:
3) High Blood Pressure?	Yes:	No:
If yes, is it controlled with medication?	Yes:	No:
4) Irregular Heart Beat (Arrhythmia)	Yes:	No:
5) Congestive Heart Failure (CHF)	Yes:	No:
3) Pacemaker or ICD	Yes:	No:
4) Internal defibrillator	Yes:	No:
5) Blood Clots	Yes:	No:
6) Cramping	Yes:	No:

Other: Specify \_\_\_\_\_

**5) LUNG/ BREATHING PROBLEMS**

1) Asthma	Yes:	No:	
2) Bronchitis	Yes:	No:	
3) Emphysema	Yes:	No:	
4) Sleep Apnea	Yes:	No:	
5) Pulmonary Embolism	Yes:	No:	Date:

Other: Specify \_\_\_\_\_

1. Do you become short of breath when walking around the house? Yes \_\_\_ No \_\_\_
2. Do you become short of breath walking one block? Yes: \_\_\_\_\_ No: \_\_\_\_\_
3. Are you able to climb 4-5 steps to get on the bus? Yes: \_\_\_\_\_ No: \_\_\_\_\_

**6) OXYGEN AND BREATHING EQUIPMENT**

I use Oxygen	Yes:	No:
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*If yes, please answer 1-3 that apply to you:*

- 1) What is your flow setting? \_\_\_\_\_
- 2) How many hours a day do you use oxygen? \_\_\_\_\_
- 3) If you know, what is your normal oxygen saturation? \_\_\_\_\_ %

**Note: A doctor's prescription is required to use portable oxygen. You will need to contact your doctor to write the prescription and then submit it to Honor Flight Austin at least 3 weeks before departure date.**

I will be traveling with CPAP	Yes:	No:
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Settings: \_\_\_\_\_

I will be traveling with BiPAP	Yes:	No:
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Settings: \_\_\_\_\_

I use a nebulizer machine for my breathing treatments	Yes:	No:
-If yes will you bring your own nebulizer on the trip?	Yes:	No:

**Note: You are STRONGLY encouraged to discuss the use of a portable nebulizer or an inhaler during the trip with your physician**

**7) CANCERS**

- 1) Have you been diagnosed with Carcinoma, Sarcoma, Leukemia, Lymphoma, and/or Myeloma in the past? Yes: \_\_\_\_\_ No: \_\_\_\_\_
- 2) If yes, please list what type: \_\_\_\_\_  
\_\_\_\_\_
- 3) In the past 3 months, have you received treatment (Chemotherapy, Radiation, surgery, transfusions)? Yes: \_\_\_\_\_ No: \_\_\_\_\_
- 4) If yes, please list what type and date of last treatment: \_\_\_\_\_  
\_\_\_\_\_

**MEDICATIONS:** You are welcome to attach a pre-printed list of your medication as long as it has the name of the drug, dosage, and how often you take it.

NAME OF MEDICATION	DOSAGE	HOW OFTEN?

Is there anything else we should know about your physical/medical situation or special needs please explain here. Feel free to add attachments and if you feel that waiting will be an issue for the Veteran to be on our Flight later than right away, please explain here as well.

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***Thank you for answering and submitting this assessment.***

***We want to respect your health care wishes. If you have an advance directive, durable power of attorney, or other health care documents that you would like us to carry on the trip, please send them with this assessment.***

***All information provided by you, including all health information is strictly confidential and WILL NOT be shared with anyone except appropriate Honor Flight staff. All HIPAA guidelines are strictly followed by Honor Flight Austin***

**PLEASE REVIEW CAREFULLY AND SIGN (REQUIRED):**

This 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 Austin from all claims and liability relating to said photographs. I hereby give permission for my images captured during the Honor Flight activities through video, photo, or other media, to be used solely for the purpose 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 injuries incurred by me while participating in the Honor Flight program.

SIGNED: \_\_\_\_\_  
(If submitting through email please type the following in signature block **//Signed// NAME OF VET**)

DATE: \_\_\_\_\_