DESERT WARRIOR HONOR FLIGHT

Honor Flight Austin Application

Honor Flight Austin will be providing an all-expense paid trip to Washington D.C. for combat veterans who served in the Gulf War – Present. This unique sponsored community flight is to honor the brave men and women for serving our country when our Nation needed you the most and for the sacrifices you made to keep our country safe and free to this day.

Requirements to be selected for this flight

Veterans must be a ***combat veteran*** who served ***in country*** during the following years and residing within 14 surrounding counties of Austin stated below.

(Gulf War): August 2, 1990 through (OIF, OEF) to Present Day Combat Operations

Honor Flight Austin serves the following 14 counties: Bastrop, Bell, Blanco, Burnet, Caldwell, Fayette, Gillespie, Gonzales, Hays, Lee, Llano, Milam, Travis, and Williamson Counties.

General Information

- Applications are logged in the order of when the application is postmarked/received. There are 50 seats available
- Our Flight schedule is April 26-27 (Friday- Saturday)
- 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 if the flight is full and someone is no longer able to make it, there is a chance you will 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. All Veterans will have someone to room with overnight and no one will be staying alone.
- 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.

Please submit applications and any other paperwork to the following address:

Honor Flight Austin
ATTN: DESERT WARRIOR FLIGHT
815 A-Brazos St, UPS Box 498
Austin, Texas, 78701

Email: Tina.lee@honorflightaustin.org

FAX: 512-974-2712

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 once again for your service.

FOR HONOR FLIGHT AUSTIN USE ONLY DATE RECEIVED_________________ LAST NAME _________________________

Desert Warrior Honor Flight Application

Honor Flight Austin recognizes and honors American veterans for your sacrifices and achievements by flying you to Washington, DC to see the memorials built in honor of your service at **NO COST**. Please consider this a small token of appreciation from all of us at HFA and for further information, please contact us toll free at 1-888-530-8880 or visit our website at 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

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:

Military Branch of Service: ____

Military Rank at Completion of Service: ____

Which Operation (In Country) did you serve in? ________________________________

What locations did you serve in?

____
____
____

What was your MOS/AFSC (Job title/not code) in the military? _____________________
____

Activity during your service (theatre of operation, unit, division, battalion, ship, plane, etc):

____
____
____
____

Dates in service and if still active____

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. Email would be great if they have one.*
(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: ____

FOR HONOR FLIGHT AUSTIN USE ONLY

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?

	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, difficulty or needing 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	☐	☐	☐

1. Are you ***ABLE*** to climb/walk 4-5 steps to get on/off the bus more than once?

Yes: ☐ **No:** ☐

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

Any specific medical concerns we should be aware of that would affect you during the trip?

____

____

____

PLEASE CHECK THE BOXES THAT APPLY TO YOU

1) NUTRITION AND/ OR GI PROBLEMS

A. Diabetes	Yes: ☐	No: ☐

Insulin: ☐ Oral Medication: ☐ Both: ☐

I monitor my blood sugar myself: Yes: ☐ No: ☐

B. Diet/Food restrictions, requirements, or allergies	Yes: ☐	No: ☐

Please explain____

____

C. Urostomy Bag:	Yes: ☐	No: ☐	**D.** Colostomy Bag:	Yes: ☐	No: ☐

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

A) Dementia	Yes: ☐	No: ☐
B) Alzheimer's	Yes: ☐	No: ☐

SKIP QUESTIONS 1-4 BELOW IF YOU MARKED "NO" FOR BOTH QUESTIONS ABOVE

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: ____

C) Stroke	Yes: ☐	No: ☐	If yes, what year?

If yes, explain any resulting problems ____

____

D) Parkinson's Disease	Yes: ☐	No: ☐
E) Motion Sickness	Yes: ☐	No: ☐
F) Epilepsy or Seizures?	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

FOR HONOR FLIGHT AUSTIN USE ONLY
DATE RECEIVED________________ LAST NAME ________________________

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

A) EYES

1) Infection, inflammation, other problems	Yes: ☐	No: ☐

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: ☐

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:

1) Any problems with imbalance and/or dizziness?	Yes: ☐	No: ☐

Please explain: ____

____

C) NOSE AND SINUSES

Infection, inflammation, allergies?	Yes: ☐	No: ☐

Please explain: ____

____

D) THROAT

Any difficulty swallowing?	Yes: ☐	No: ☐

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

Heart Attack?	Yes: ☐	No: ☐	If yes, what year(s)

1. Chest Pain?	Yes: ☐	No: ☐
1a. If yes, is it controlled with medication?	Yes: ☐	No: ☐
2. High Blood Pressure?	Yes: ☐	No: ☐
2a. If yes, is it controlled with medication?	Yes ☐	No: ☐
3. Irregular Heart Beat (Arrhythmia)	Yes: ☐	No: ☐
4. Congestive Heart Failure (CHF)	Yes: ☐	No: ☐
5. Blood Clots	Yes: ☐	No: ☐
6. Cramping	Yes: ☐	No: ☐

Other: Specify ____

5) LUNG/ BREATHING PROBLEMS

1) Asthma	Yes: ☐	No: ☐
2) Bronchitis (Current?)	Yes: ☐	No: ☐
3) Emphysema	Yes: ☐	No: ☐
4) Sleep Apnea	Yes: ☐	No: ☐
5) Pulmonary Embolism	Yes: ☐	No: ☐

Other: Specify____

2. Do you become short of breath walking one block? Yes: ___☐___ No:___☐___

6) OXYGEN AND BREATHING EQUIPMENT

I use Oxygen	Yes: ☐	No: ☐

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: ☐

Settings: ____

I will be traveling with BiPAP	Yes: ☐	No: ☐

Settings: ____

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

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

FOR HONOR FLIGHT AUSTIN USE ONLY

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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?

If there is anything else we should know about your physical/medical situation or special needs please explain here. **Feel free to add attachments** 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 and any other pertinent information regarding your health.

____
____
____
____

Thank you for answering and submitting this assessment. Please know that anything you say WILL NOT disqualify you from going on the Honor Flight, so please answer all the necessary questions.

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: ________________________