FOR HONOR FLIGHT RIO GRANDE VALLEY USE ONLY

DATE RECEIVED_____ LAST NAME _____

Honor Flight Rio Grande Valley Application and Pre-Flight Checklist

Honor Flight Rio Grande Valley 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 (For which we are currently accepting applications) is given to our WWII and terminally ill Veterans from all wars. In order for Honor Flight Rio Grande Valley 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 HFRGV. For further information, please contact us toll free at 1-888-410-0450 or visit our website at www.honorflightriograndevalley.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_____ Nickname: _____

Date of Birth: Month: _____ Day: _____Year: 19_____

Gender (Male, Female) _____ *Weight:* _____

Address: _____

City: _____, **Texas** , Zip Code_____

Phone Numbers: **Home** (_____) _____, **Cell** (_____) _____

Email: _____

Polo Shirt Size: (*Small, Medium, Large, XL, XXL, XXXL*) _____

PLEASE NOTE THAT OUR 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			

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MILITARY SERVICE HISTORY:

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 WWII (Theatre of Operation, unit, division, battalion, ship, plane, etc):

_____

_____

_____

_____

_____

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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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 10 stairs	☐	☐	☐
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:

1) NUTRITION AND/ OR GI PROBLEMS

A. Diabetes	Yes: ☐	No: ☐

If yes, please check the following boxes that apply to you:

Insulin: ☐	Oral Medication: ☐	Both: ☐
I monitor my blood sugar myself	Yes: ☐	No: ☐
I manage my own medication	Yes: ☐	No: ☐

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

Please explain_____

_____

C. Urostomy Bag: ☐	Colostomy Bag: ☐	
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: ☐

If YES to any of the selections above, please answer and check the following boxes that apply to you. If you do not have the two above then you do not have to answer 1- 4

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: ☐
- If yes, is it controlled with medication?	Yes: ☐	No: ☐
F) Epilepsy or Seizures?	Yes: ☐	No: ☐

If yes, what was the date of your last seizure? _____

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Type of Seizure if known:	Tonic Clonic: ☐	Absence: ☐	Other: ☐

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

3) EYE, EAR, NOSE, THROAT PROBLEMS

A) EYES

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

Please explain: _____

_____

2) Loss of Sight	Yes: ☐	No: ☐

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: ☐

Please explain: _____

_____

2) Loss of Hearing	Yes: ☐	No: ☐

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

Right Ear	Percentage Loss:
Left Ear	Percentage Loss:

3) 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: _____

_____

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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: ☐
3) Pacemaker or ICD	Yes: ☐	No: ☐
4) Internal defibrillator	Yes: ☐	No: ☐
5) Blood Clots (Especially lower extremities)	Yes: ☐	No: ☐
6) Cramping (Especially lower extremities)	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_____

Please check any of the boxes that apply to you.

In the past 3 months I have become short of breath:

At Rest:	☐
Walking one (1) Block:	☐
Walking three (3) Blocks:	☐
Climbing ten (10) Stairs:	☐
Never:	☐

6) OXYGEN AND BREATHING EQUIPMENT

I use Oxygen	Yes: ☐	No: ☐

If yes, please check boxes 1-4 that applies 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?	%
4) Will you require portable Oxygen during the flight?	

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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 Rio Grande Valley 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: ☐	No: ☐

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

7) PREVIOUS INJURIES

Have you had any previous injuries (open/closed head injuries) that may impact your ability to fly?	Yes: ☐	No: ☐

If yes, please check the following boxes that apply to you:

1) Have you flown since these injuries occurred?	Yes: ☐	No: ☐
2) Did you have any difficulties when you flew?	Yes: ☐	No: ☐

Please explain: _____

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

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?

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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.

_____
_____
_____
_____
_____

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 Rio Grande Valley.

Due to the amount of applications we receive, giving any confirmation of receiving your application is limited. If you have questions on the application or would like the acknowledgement of Honor Flight Rio Grande Valley receiving your application please contact us at 1-888-410-0450 and she will confirm with you. Please note that we will normally contact you a month prior to your flight and give you all the necessary information at that time about your trip.

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PLEASE REVIEW CAREFULLY AND SIGN:

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 Rio Grande Valley 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: _____ /_____/_____

Please submit this form to:
Honor Flight Rio Grande Valley
ATTN: Veteran Application
P.O. Box 5840
McAllen, Texas, 78502

Or

Email: valeriegonzalez.hfrgv@gmail.com

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Reviewed By: _____ Date: _____