Thank you for considering joining Honor Flight of Southern Colorado for an amazing trip to Washington DC.

Very briefly, we travel with Veterans on a three-day Honor Flight to Washington, DC to visit and reflect at the WWII Memorial. Many, many travelers, students, and other memorial visitors, will greet you and want to shake your hand to express their gratitude and offer their well wishes. The Honor Flight trip also includes the Korean War Memorial and the Vietnam Memorial Wall. Other memorials are included when possible. The last stop is Arlington National Cemetery. The changing of the guard at the Tomb of the Unknowns is a moving and emotional experience.

We hope that you will visit with other veterans on the trip, talk about visiting the memorial, and compare 'war stories'. We hope you experience just how much we, your families and friends, and indeed the entire country, appreciate you and what you and your generation - the greatest generation - have done for the United States of America.

Attached you will find an application for Honor Flight of Southern Colorado. Please complete it and send it to us. The following list includes the other forms and information we will need prior to your flight - usually 30 days prior. It is included to give you time to gather the information.

- ☐ Your completed application including the medical information (please send that to us as soon as it is complete)
- ☐ A copy of the identification you will use to get through TSA at the airport (driver's license, retired military ID card, passport, etc.)
- ☐ A statement from your physician or care provider that they consider you able to travel.
- ☐ Your complete, up-to-date list of medications.
- ☐ A copy of your Living Will, Advance Directive or Do Not Resuscitate instructions IF you have made those decisions.
- ☐ IF YOU ARE ON OXYGEN, the Physician Consent Form for an Individual Who Needs to Use a Portable Oxygen Concentrator (POC) During a Southwest Airlines Flight (Must be completed in full by the Passenger's physician and copied onto physician's letterhead) - attached. <u>This form can be used on Southwest Airlines AND to have oxygen delivered in Washington.</u>

We truly hope you will travel with us. If you have questions, please call 719-258-9946 and leave a message. We will get in touch.

The Board of Directors, Honor Flight of Southern Colorado

HONORFLIGHT of Southern Colorado

Veteran Application

VETERAN APPLICATION: Honor Flight of Southern Colorado recognizes the service and sacrifice of our American Veteran by offering to you, a free all-expenses paid trip to Washington DC. to visit the many memorials and monuments dedicated to the armed services. We are currently accepting application to veterans from WWII and/or terminally ill veterans from all wars. Honor Flight of Southern Colorado provides trained guardians who escort our veterans, offering assistance for a safe, memorable and rewarding journey.

Please complete **all** parts of this application form. All information is confidential.

Complete Name as it appears on the identification you use for travel – attach a copy if possible		
First	Middle	Last
Address		
City	State	Zip Code
Phone - Home	Phone - Mobile	
E-Mail		

T-SHIRT SIZE: S M L XL XXL XXXL (please circle) HEIGHT: _____ WEIGHT: _____

SERVICE HISTORY:

WWII O Yes O No	Korean O Yes O No	Vietnam O Yes O No
Branch of Service		Rank at Discharge
Where did you enter the Service? City	State	
What date did you enter the Service?	Discharge Date	
Duty Stations		

PLEASE PROVIDE A BRIEF BIOGRAPHY OF YOUR SERVICE THAT WILL BE SHARED WITH OTHERS UPON SELECTION – this will be published in our pre-flight book. You should start working on a longer more complete story regarding your service.

Please continue on back of form (if needed)

HAVE YOU EVER, been on an Honor Flight Trip, or visited the Memorials with any other Organization? O Yes O No

If so, WHEN_____and with WHO?_____

Rooms are shared. Would you like to room with another veteran or a guardian? O Veteran O Guardian
(Actual room assignments are determined after the Pre-Flight luncheon and conversation with the HF Medical Team).

Veteran Signature Required:

1. By signing this document I give permission for my Doctor or Care Provider holding any of my medical records to interact with HONOR FLIGHT of SOUTHERN COLORADO. Members of HFSOCO may contact my Doctor or Care provider to inquire about medications, or treatments to ensure my continued safety during the Honor Flight.
2. I acknowledge that I am about to voluntarily participate in various activities with Honor Flight of Southern Colorado, for myself, my heirs, administrators, executors and assigns, hereby covenant and agree that I will never institute, prosecute, or in any way aid in the institution or prosecution of, any demand, claim or suit against the organization, its volunteers, guardians, board member and agents.
3. I also understand and agree that I may be held liable for any damages or loss to the Honor Flight Network and or Honor Flight of Southern Colorado which is caused by my gross negligence, willful misconduct, dishonesty, or fraud.
4. I understand that in the event of a medical emergency, HFSOCO will call 911 and any medical costs incurred are not the responsibility of Honor Flight of Southern Colorado or Honor Flight Network.
5. I understand that photographic and recording equipment are used to document the trip and that images may appear in a public forum. I hereby release the photographer and HFSOCO from all claims and liability to said photographs and video.
6. I authorize HFSOCO to release my contact information to others who participate in the same flight for purposes of communication and camaraderie with other participants. **If you do not wish** for your information to be released, please check here_____.

PRINT NAME: _____

SIGNATURE: _____

DATE_____

Return application to:
Honor Flight of Southern Colorado
PO Box 50816
Colorado Springs, CO 80949

Honor Flight of Southern Colorado: Medical History Questionnaire

Please fill out this questionnaire as completely as possible. Keeping you safe and healthy is our priority. Our medical team will review this information, and may contact you for any clarification that is required. Likewise, please feel free to contact our medical liaison for any concerns. All medical information is kept strictly confidential. All information will be destroyed after your flight.

A physician / primary care provider statement that you are cleared to go on trip will be required by date of Pre-Flight Luncheon

Last Name: First Name:

Nick Name: Age: Date of Birth:

This section MUST BE COMPLETED:

Emergency contact:

Relation of emergency contact: Emergency contact phone:

Emergency contact E-Mail

Primary Physician: Primary Physician phone:

Do you have an advanced directive, living will, or Do Not Resuscitate order in place?

NO **YES (provide copy)**

Mobility Assessment: Please check **ALL** appropriate choices:

Can you walk a half mile?	Easily, without assistance O Yes O No	Slowly O Yes O No	Would need assistance O Yes O No
Can you go up and down 3 or 4 steps onto bus?	Easily, without assistance O Yes O No	Slowly O Yes O No	Would need assistance O Yes O No

Do you use a cane?
O Yes
O No
O Sometimes

Do you use a walker?
O Yes
O No
O Sometimes

Do you use a Wheelchair?
O Yes
O No
O Sometimes

Do you use a scooter or motorized wheelchair? (Veteran owned & necessary)
O Yes
O No
O Sometimes

Do you have any physical limitations for the trip that you know about? Please describe:

Have you fallen in the past 6 months? O Yes O No (Please describe fall and injuries sustained)

Medical Assessment:

Please fill out to the best of your ability. Circle or check the most appropriate response, and **if you answer yes to any of the following, please provide additional details in the space provided below each category.** If you require oxygen, please see medication section to provide details regarding your oxygen needs.

Have you been diagnosed with, or do you experience any of the following conditions:

Hearing problems Limitations, details and special needs
O Yes O No

Vision Problems Limitations, details and special needs
O Yes O No

Asthma O Severe O Moderate O Mild Have you every required intubation? O Yes O No
O Yes O No

Balance / Dizziness Details
O Yes O No

CHF Do you require Oxygen? (if yes, complete oxygen section)
O Yes O No
O Yes O No

COPD Do you require Oxygen? (if yes, complete oxygen section)
O Yes O No
O Yes O No

Cancer Details
O Yes O No

Diabetes Type Do you Insulin? Injectable Pump
O Yes O No O Yes O No O Yes O No
O Yes O No

Renal / Kidney disease Details
O Yes O No

AICD / Defibrillator Date of last shock Other pertinent details
O Yes O No

Heart Attack Date Stents How many?
O Yes O No
O Yes O No

Heart Bypass Surgery Date Other pertinent details
O Yes O No

Heart Disease Details
O Yes O No

Irregular Heart Rhythm Type
O Yes O No

Pacemaker Type
O Yes O No

Do you have a urostromy or colostomy bag? Details
O Yes O No

Back problems/surgery Limitations and other details
O Yes O No

Joint problems What joint? Details
O Yes O No

Stroke / TIA
○ Yes ○ No

Date

Did you receive a clot dissolving drug?
○ Yes ○ No
Any residual symptoms:

Please circle the choice that most accurately describes your living situation:

A. Live in my own home independently
B. Live in my own home with part time help/ family
C. Live in my home with full time help/ family
D. Live in an assisted living facility
E. Live in a skilled nursing facility with full time care

Please indicate the statement that accurately describes you:

A. I never have accidents involving urine or bowels
B. I rarely have accidents – but occasionally wear protective clothing
C. I routinely wear protective clothing
D. I self- catheterize, or have an indwelling catheter

Please select the choice that best describes you:

A. I am able to bathe myself and use the restroom independently
B. I am able to bathe, and use the restroom independently
C. I need assistance with activities of daily living

Allergies to Medication or food:

Medication or food	Allergy / Reaction

Do you have any dietary restrictions attributed to a current medical condition or medication?
○ Yes ○ No

Details

Oxygen Users Only: Please note: An additional airline form is attached. **We need this form for you to be able to use oxygen on the flights to and from Washinton AND to have oxygen available for you in Washington.** Please have your prescribing physician complete this form and send it to the address above. It does not have to accompany your application but it is required at least 30 days after we receive your application.

Please circle most appropriate statement

I use oxygen full time

Prescribed # of liters _____

I use oxygen only at night

Prescribed # of liters _____

I use oxygen only as needed or for exertion

Are you able to operate your own oxygen equipment? ○ Yes ○ No

Do you use a CPAP or BiPAP at night?

CPAP
○ Yes ○ No

BiPAP
○ Yes ○ No

Do you take the equipment with you when you travel?
○ Yes ○ No

Medication Inventory:

- O I am able to take all medications without assistance
- O I am able to take all medications without assistance but would like reminders.
- O I require assistance with taking my medication

Please fill out the medication inventory with as much detail as possible. Please feel free to use the comment space to transcribe the exact instructions listed on your prescription bottles. Otherwise, use the template to indicate your medications and schedule.

*****If HF med team or guardians will be assisting with medication delivery, medications must be clearly marked and identifiable. Name of person taking medications must be on the container, medications should be identified (or there should be a legend to help HF staff know what is what). Clear instructions must accompany the medications.**

Medication	**Dose** (mg, # of tabs, etc.)	**Route** (oral, inhaled, injected, etc.)	**Frequency:** once per day/ twice a day etc..	**Comments**
Example: Levothyroxine	*75 mcg*	*Oral*	*Once daily before breakfast*	
Example: Tobradex (eye drops)	*2 drops*	*Eye drops*	*3 times per day*	

Please make additional copies of this page if more room is needed. Please use back of form to provide any additional information.

Physician Consent Form for an Individual Who Needs to Use a Portable Oxygen Concentrator (POC) During a Southwest Airlines Flight

(Must be completed in full by the Passenger's physician and printed on physician's letterhead)

Physician's Name: _____
Place of Business: _____
Address: _____
_____
Telephone: _____
Fax: _____

Please note that, in accordance with Special Federal Aviation Regulation (SFAR) No. 106, 14 CFR Part 121, only the **AirSep FreeStyle, AirSep LifeStyle, Inogen One, Respironics EverGo, and SeQual Technology Eclipse POC** models are approved for use during flight. Compressed or liquid medical oxygen may not be used or transported on Southwest Airlines.

The following information relates to _____, who is a patient in my care. He/She:
(Passenger/Patient name)

- is able to operate the POC and recognize and respond appropriately to its alarms. **Yes**_____ **No**_____ If the answer is no, the Passenger/Patient must travel with a companion who is able to perform these functions. _____ **(initial)**
- will require the use of the device during (check all that apply) taxi___, takeoff___, in air___, and/or landing___.
- will be using a device with a maximum oxygen flow rate of _____, corresponding to the pressure of the aircraft under normal operating conditions. (Cabins are pressurized to an altitude of 8,000 feet.)

_____ _____
(physician signature) **(date)***

***Form must be dated within one year of travel date.**

NOT VALID UNLESS PRINTED ON PHYSICIAN'S LETTERHEAD