

# **SOUTHEAST MISSOURI HONOR FLIGHT Inc.**

## **VETERAN APPLICATION**

Honor Flight recognizes American Veterans for your sacrifice and achievements by flying you to Washington, D.C. to see YOUR memorials at no cost. Currently, we are honoring WW II, Korean and Vietnam War era veterans. Top priority is given to terminally ill veterans from any conflict. In order for Honor Flight to achieve this goal, an escort/guardian will accompany you on the flight, providing assistance and helping you 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 Southeast Missouri Honor Flight, Inc. (SEMOHF). For further information, please contact us at (573-883-6169).

(NAME) LAST: \_\_\_\_\_ FIRST: \_\_\_\_\_ MIDDLE: \_\_\_\_\_  
(REAL ID or Passport is required for airline travel, please provide copy/photo of ID with application)

Nick Name \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ GENDER: (M) (F)

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ COUNTY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

PHONE: (Day): \_\_\_\_\_ (Evening): \_\_\_\_\_ (Cell) \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

SHIRT SIZE (please circle): **S M L XL 2XL 3XL** \_\_\_\_\_

SERVICE HISTORY: Branch of Service: \_\_\_\_\_ Rank: \_\_\_\_\_ Service Dates: \_\_\_\_\_

Hometown (City and State from which you entered the military): \_\_\_\_\_

Activity during your tour of service: \_\_\_\_\_

Are you requesting to travel with a specific Veteran or Guardian, if possible? YES NO If yes,

please name the Veteran: \_\_\_\_\_ Relationship: \_\_\_\_\_  
(Note: Veteran application must be submitted separately).

please name the Guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_  
(Note: Guardian application must be submitted separately).

**EMERGENCY CONTACT** (someone available on the day you travel, who is not traveling with you):

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

PHONE: (Day) \_\_\_\_\_ (Evening): \_\_\_\_\_ (Cell): \_\_\_\_\_

**ALTERNATE CONTACT** (someone different than listed above):

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

PHONE: (Day) \_\_\_\_\_ (Evening): \_\_\_\_\_ (Cell): \_\_\_\_\_

**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 trips and events, your image may appear in a public forum, such as the media, Facebook, or a website, etc., to acknowledge, promote or advance the work of the Honor Flight program. I hereby release the photographer and SEMOHF, Inc. from all claims and liabilities relating to said photographs. I hereby give permission for my images captured during 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 SEMOHF, Inc. responsible for any illnesses or injuries incurred by me while participating in the Honor Flight program.
3. In addition, any errors or omissions in this application may be reason to deny your participation.

**Printed Name:** \_\_\_\_\_

**SIGNED:** \_\_\_\_\_

**DATE:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Please fill out completely, sign and then mail or email to:

Kendall Shrum

P.O. Box 42

Ste. Genevieve, Mo. 63670

Phone No.: (573) 883-6169

SEMOHF-Guardian Application 2025

Email: semohonorflight@gmail.com

(NAME) LAST: \_\_\_\_\_ FIRST: \_\_\_\_\_ MIDDLE: \_\_\_\_\_

**MEDICAL HISTORY - THE INFORMATION YOU PROVIDE WILL NOT DISQUALIFY YOU. IT ALLOWS US TO ASSESS THE SUPPORT NEEDED DURING THE TRIP AND WILL ONLY BE USED BY SEMOHF, Inc. FOR YOUR SAFETY.**

List any medical conditions that you are currently receiving treatment for by a physician. Also list any physical issues that would limit your ability to fulfill the duties of a guardian (e.g. push a veteran in a wheelchair, etc.)

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**MEDICATION(s)** Please list any medications being taken and how often. You may attach a separate sheet if it is more convenient)

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Please list any allergies: \_\_\_\_\_

Do you have any dietary restrictions? NO YES \_\_\_\_\_

Do you use mobility equipment? NO YES If YES, please circle the device: Cane Walker Wheelchair

Do you have a history of seizures? NO YES Last Seizure date: (If within the past 5 years, it is STRONGLY advised you discuss the trip with your doctor)

Do you have a problem with motion sickness (air/etc.)? NO YES If yes, is it controlled with medication? YES NO

Do you have a breathing problem? NO YES If YES, please describe: \_\_\_\_\_

Do you use Oxygen at any time? NO YES

If YES, you will need an oxygen prescription from your doctor to be able to use oxygen during the trip. The prescription should be included with your application. Additionally you should equip yourself with a Portable Oxygen Concentrator during the trip, as the airline does not allow oxygen on their aircraft.

Do you have a problem walking the length of a football field? NO YES

Are you able to walk up and down a short flight of stairs? (i.e. charter buses have stairs) NO YES

Any additional comments: \_\_\_\_\_

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Note: IF YOU ANSWERED YES TO ANY OF THE MEDICAL QUESTIONS, YOU ARE STRONGLY ADVISED TO DISCUSS THIS TRIP WITH YOUR DOCTOR.