SOUTHEAST MISSOURI HONOR FLIGHT Inc.
GUARDIAN APPLICATION

Honor Flight would not be successful without the generous support of guardians who play a significant role on every trip ensuring that every veteran has a safe and memorable experience. Duties include – but are not limited to – interviewing and getting to know your veteran(s) before the trip and assisting your veteran(s) throughout the day during travel and at the memorials. Guardians pay their own expenses (airline fare, meals, etc.) to SEMOHF, Inc. in advance. For further information, please call us at (573) 883-6169**.** Thank you for your support.

(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** _____

OCCUPATION: _____

Are you a veteran? **NO YES (**if YES, please indicate the BRANCH of service, WHEN and WHERE you served)

_____

Are you requesting to travel with a specific veteran, if possible? **NO YES**

If yes, please name the veteran:_____ Relationship: _____
(Note: veteran 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:*** ____/____/_____

If under 18, a parent/guardian must also sign and date below. By signing this form, it gives the Southeast Missouri Honor Flight, Inc. permission to arrange for emergency medical treatment, if needed.

Printed Name: _____ ***[1]Relationship*** _____

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

Email: semohonorflight@gmail.com

[1]

(NAME) LAST: _____ FIRST: _____ MIDDLE: _____

MEDICAL HISTORY *- **THE INFORMATION YOU PROVIDE WILL NOT DISQUALIFY YOU. IT ALLOWS US TO ASSESS YOUR ABILITY TO SUPPORT A VETERAN 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.)

_____

_____

_____

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

_____

_____

_____

_____

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.)? YES NO If yes, is it controlled with medication? YES NO

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

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

Can you lift 100 Pounds? NO YES

Any additional comments: _____

_____

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