FRANKLIN COUNTY 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 FCHF, Inc. in advance. For further information, please call us at (636) 584-5253 or visit www.fchonorflight.org or on Facebook at Franklin County Honor Flight – Missouri**.** Thank you for your support.

(NAME) LAST _____ FIRST _____ MIDDLE _____

Nick Name _____ DATE OF BIRTH _____ GENDER (M) (F)
(As it appears on your ID for airline travel)

ADDRESS _____

CITY _____ COUNTY _____ STATE ____ ZIP CODE _____

PHONE (Day) _____ (Evening) _____ (Cell) _____

EMAIL ADDRESS _____

SHIRT SIZE (please circle) **S M L XL 2XL 3XL 4XL 5XL** CAN YOU LIFT 100 POUNDS? **YES NO**

OCCUPATION _____

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

_____

EMERGENCY CONTACT (someone available on the day you travel)

NAME _____ RELATIONSHIP _____

PHONE (Day) _____ (Evening) _____ (Cell) _____

ALTERNATE CONTACT (someone other than the above who is available on the day you travel)

NAME _____ RELATIONSHIP _____

PHONE (Day) _____ (Evening) _____ (Cell) _____

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 FCHF, Inc. FOR YOUR SAFETY.***

List any medical conditions for which you are currently receiving treatment from 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.)

_____

_____

_____

Please continue on to the next page

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

MEDICATION	*TAKEN HOW OFTEN*	*MEDICATION*	*TAKEN HOW OFTEN*

Please list any allergies _____

Do you have a history of seizures? _____

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? **YES NO** If YES, please describe _____

Do you have any history of **open head injuries, sinus problems, or ear problems? YES NO**
If YES, have you flown since the problem? **YES NO**

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

Please list any medical experience you may have (e.g. First Responder, EMT or EMT-P, etc.)

_____

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

If yes, please name the veteran_____ Relationship _____
(Note veteran application must be submitted separately).

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 ***FCHF, 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 risk associated with travel and other Honor Flight activities and will not hold ***FCHF, Inc.*** responsible for any illnesses or injuries incurred by me while participating in the Honor Flight program.
3. As part of your eligibility for consideration to participate with the ***FCHF, Inc.*** program, a criminal background check will be completed for each application.
4. In addition, any errors or omissions in this application may be reason to deny your participation.

SIGNED _____ ***DATE*** ___/___/_____

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

SIGNED _____ ***DATE*** ___/___/_____

Please fill out completely, sign and then mail or email to
Rosalie McGaugh
311 Madelyn Ct.
Washington, MO 63090

Email mcgaughr@swbell.net

Phone No. (636) 390-1802