



Honor Flight San Antonio
14080 Nacogdoches Rd., PMB 340
San Antonio, TX 78247

Dear Veteran,

Honor Flight San Antonio (HFSA) is dedicated to honoring our veterans for the sacrifices they have made to keep our nation safe by providing them with an all-expense paid trip to visit the memorials in Washington D.C. which symbolize the spirit, sacrifice, and commitment of these veterans.

Honoring our nation's veterans with a journey of remembrance and appreciation.

Trip Criteria:

HFSA is an overnight trip flying on a commercial flight therefore, we require that you are medically, functionally, and cognitively safe to make the trip. The safe travel of the veterans is our number one priority.

Basic Information:

- Applications are reviewed and recorded in the order in which they are received.

Top priority is given to WWII, Korean veterans, and those veterans who are, doctor certified, terminally ill.

We fly in the spring and fall.

We almost always fly on Southwest Airlines (with other passengers) out of San Antonio International Airport.

Medical personnel travel with the group and are there for your safety and to respond to emergencies. **However, they are not there to provide individual daily personal/medical care.**

Please read over the following criteria that you must meet to be able to safely travel with HFSA:

- You must be a veteran to travel on HFSA.

Mail or email a copy of your DD-214, or Military Discharge form (such as SB 52 form) to us with **your social security number blacked out**. Also, send a copy of you in uniform.

- If you do not have your DD-214, you may request one online at

<https://www.archives.gov/veterans/military-service-records>

You must attend the Pre-Flight Briefing which is held prior to the flight date.

You must be able to walk 25 feet (the aisle of the plane) with or without the use of cane and/or walker. You may be asked to demonstrate this at the Pre-Flight Briefing.

You must be able to take care of yourself: bathing, toileting, transfer (i.e. moving from chair-to-chair) and eating.

If you use a walker, most of the time, you must have a family member who meets HFSA qualifications, to travel as your guardian.

If you take memory medication and/or have dementia, you must have a family member who meets HFSA qualifications, to travel as your guardian.

You will be rooming with another veteran, unless you are traveling with a guardian who is a family member.

Honor Flight San Antonio reserves the right to deny veteran's travel if found in noncompliance with Honor Flight San Antonio policies.

Mail the completed application along with the additional requested documents, medications list, DD-214, photo, etc to:

Honor Flight San Antonio
14080 Nacogdoches Rd., PMB 340
San Antonio, TX 78247

More information <http://www.honorflightsanantonio.org>
E-mail: info@honorflightsanantonio.org



Honor Flight San Antonio Pre-Flight Assessment

General Information

Honor Flight San Antonio will buy airline tickets for the group. Your name, on your ticket, must **EXACTLY** match your government issued picture I.D. that you plan to use at airport security checkpoints.

Last Name: _____

First Name: _____ Middle name or initial: (if applicable): _____ Suffix: _____

Sr. Jr. I. II. _____

What name would like to be called on the trip: _____

Date of Birth: _____

Branch/es of the Service: _____

Years served: _____

Height: _____ Feet/Inches

Weight: _____ Lbs.

Circle polo Shirt Size (small, medium, large, XL, 2XL, 3XL, 4XL)

Address: _____

City: _____, State: _____, Zip Code _____

PHONE NUMBERS Home: () _____ Cell: () _____

E-mail: _____

Please check all applicable items that apply to you:

____ Pacemaker

____ Defibrillator

____ Metal Implant i.e. hip, knee joints

____ Insulin Pump, Insulin and/or Insulin Loaded Dispensing Products

____ Liquid medications or liquid nutritional supplements

____ Oxygen

____ CPAP or BiPAP

Emergency Contacts

List two (2) people you would like us to contact in case of an emergency.

Primary Contact (someone available the day you travel)

Name: _____ Relationship to you: _____

Phone: Home () _____ Cell () _____

E-Mail: _____

Secondary Contact

Name: _____ Relationship to you: _____

Phone: Home () _____ Cell () _____

E-Mail: _____

Name of primary Doctor, the one you'd like us to call in case of emergency.

Name _____ Phone () _____

Family Guardians (wingman, butler, escort, handler)

If a family member would like to apply to be your Guardian, please fill in the information below, **and** complete a HFSA Guardian application. NOTE: A spouse and/or significant other cannot be your guardian.

Guardians make a \$500 tax-deductible donation, at the Pre-Flight Meeting.

The guardian must be **physically fit**. (Able to push a wheelchair, carry luggage, load luggage and **walk 5 miles** often while pushing a wheelchair.)

Must attend a mandatory Pre-Flight Veterans Meeting, and Guardian Training session.

Agree to abide by HF San Antonio policies and procedures.

Guardian's name **EXACTLY** as it appears on document used to travel. Guardian's relationship to you: _____

Last name: _____ First: _____ Middle: _____

Their birthdate: _____

Phone: () _____ E-Mail: _____

Circle Shirt size for polo shirt: small, medium, large, XL, 2XL, 3XL, 4XL

Medical experience: _____ What Experience: _____

Is the Guardian a Veteran: No _____ Yes _____ Branch: _____

Last Name _____ First Name _____

Physical and Health Assessment

The next sections we will be asking you questions about your physical ability and general health. The information that you provide helps us plan for the needs of each of the veterans on the trip. Additionally, it is very useful in the event a veteran needs assistance from the medical team or is taken to a medical facility.

Medicines

You are welcome to attach a pre-printed list of your medications i.e. pharmacist or doctor's office print off ~ as long as it includes all the name/s of all medication/s you take, dosage, and how often you take the medication. Many veterans have several doctors. Please include all of your prescriptions. (Attach and mail additional list(s), if needed.)

Name of Medicine	Dosage	How often do you take it?

Health Issues

___ **Medication Allergies:** If yes, list the medication/s that you are allergic to:

___ **Vision issues,** other than glasses: If Yes, please explain _____

___ **Hearing Issues:** If Yes, please explain _____

In the past 3 months I have needed help with the following activities?

Activity	Never	Some of the Time	Always
Dressing			
Using the Bathroom			
Eating			
Taking Medication			
Bathing or Showering			

Comments and/or Concerns: _____

In the past 3 months I have used the following mobility aids?

	Never	Some of the Time	Always
A Cane			
Walker			
Wheelchair			

**** Unfortunately, we cannot accommodate Motorized Units on the trip.

In the past 3 months I have had difficulty or needed assistance with the following activities?

	Never	Some of the Time	Always
Walking 25 feet			
Standing for 20 minutes			
Walking 3 blocks			
Climbing 5 stairs			
Moving around the house			
Getting up from chair			
Getting out of bed			

Additional Comments: _____

I live in an assisted living facility _____ Yes _____ No

Please check the box that applies to you.

Currently or in the past 3 years

1. NUTRITION (diabetes, food allergies, and/or special diet requests)

_____ Diabetes Please Explain:

- Insulin _____ Oral Medication _____ Diet Controlled _____

I monitor my blood sugar by myself Yes _____ No _____

I manage my own medication Yes _____ No _____

_____ I have food Allergies (i.e. peanuts, tree nuts, dairy, fish, gluten, etc.).

Please explain: _____

_____ I have a Special diet request/s. Please explain: _____

Kidneys/GI

_____ Self – catheterization

Do you maintain it by yourself? Yes _____ No _____

I have an Ostomy _____ Urostomy _____ Colostomy _____

Do you maintain it by yourself? Yes _____ No _____

Have you flown with the ostomy? Yes _____ No _____

I have trouble with my ostomy while traveling Yes _____ No _____

NOTE:

1. If you have an ostomy or use catheters be sure to bring extra supplies along on the trip.

Make sure your bag is vented prior to flight. If you don't know if it is vented please discuss this with your physician.

_____ I am on Dialysis Please Explain: _____

Last Name _____ First Name _____

CENTRAL NERVOUS SYSTEM

_____ Dementia, Alzheimer's, and/or cognitive challenges? Yes No

Please Explain: _____

If you checked, please answer the following questions

I participate in activities outside of my home? Yes _____ No _____

I am more confused in the evenings? Yes _____ No _____

When was the last time you spent the night away from home?

_____ I am comfortable in crowds? Yes _____ No _____

If No, please explain: _____

_____ History of **Diagnosed PTS**: Please explain _____
(Submit medical diagnosis of PTS.)

_____ **History of a traumatic brain injury** (open-closed head injury)?

Please explain _____ Year _____

Type of injury _____

_____ **Stroke**: Year of stroke _____ Please Explain: _____

_____ **Epilepsy or Seizures**:

What was the date of your last seizure? _____

Type of seizure: Grand mal _____ Petit mal _____ Other _____

_____ **Parkinson's Disease**? Please Explain: _____

SINUS PROBLEM

Sinus problems Please explain:

_____ **Motion sickness:** Please Explain: _____

Heart

_____ Heart attack? Year? _____

_____ Stent/s? Year? _____ Number _____

_____ By-pass? What Year? _____

_____ Heart failure?

_____ High blood pressure?

_____ Irregular heartbeats (Arrhythmia)

_____ Pacemaker

_____ Internal Defibrillator

_____ Congestive Heart Failure (CHF)

_____ Blood Clots? Number? _____

_____ Other, specify: _____

LUNG and BREATHING PROBLEMS

_____ Asthma

_____ Bronchitis

_____ COPD (Chronic Obstructive Pulmonary Disease)

_____ Emphysema or Chronic Bronchitis

_____ Pulmonary Embolism

_____ Sleep Apnea

_____ I become short of breath when walking around the house

_____ I become short of breath walking one block.

_____ Other, specify: _____

OXYGEN and BREATHING EQUIPMENT

_____ I use Oxygen. Yes _____ No _____

What is your flow setting? _____

How many hours a day do you use oxygen? _____

If you know, what is your normal oxygen saturation? _____%

_____ **Sleep Apnea** I will be traveling with CPAP or BiPAP Please Explain: Pressure
Settings: _____

I use oxygen with CPAP/BiPAP my flow setting is _____

I use a **nebulizer machine** for my breathing treatments _____

Medication/s _____

How often do you take your treatments? _____

Cancers

_____ In the past year I have been diagnosed with Carcinoma, Sarcoma Leukemia,
Lymphoma and/or Myeloma?

If YES, what type? _____

In the past 3 months I have received treatment

Chemotherapy: Frequency _____

Radiation: Frequency _____

Surgery Date(s) _____

Other treatments _____

Advance Directives

We want to respect your health care wishes. If you have an advance directive, durable power of attorney, or other health care document that you would like us to carry on the trip, please send in with this application or bring to Pre-Flight Veterans Meeting.

Additional Information

Is there anything else we should know about your physical/medical situation or special needs. Feel free to add attachments.

Veteran Signature Required:

The undersigned acknowledges and agrees that the information on this application is correct. If any of this information is falsified or pertinent medical information is omitted, or if my medical conditions change are determined by Honor Flight San Antonio to be unacceptable to participate, I understand I may be disqualified from participating in an Honor Flight at the sole discretion of Honor Flight San Antonio.

To ensure my continued safety during the trip with Honor Flight San Antonio, members of the HFSA Medical Team may contact my Doctor or Care provider to inquire about medications, physical status and/or treatments. I do hereby give permission for my Doctor and/or care provider holding any of my medical records to interact with Honor Flight San Antonio.

PRINT NAME: _____

SIGNATURE: _____

Date _____

If the Veteran was assisted in completion of this form, please sign here and print your name, relationship, phone number and email:

Please sign your name: _____

Print your name: _____ Relationship _____

Phone number: _____

Email: _____

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 San Antonio 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/s and Honor Flight San Antonio from all claims and liability relating to said photographs. I hereby give permission for my images captured during Honor Flight San Antonio activities through video, photo, or other media to be used solely for the purposes of Honor Flight promotional material and publications and waive any rights or compensation or ownership thereto.

I further state that medical insurance is the responsibility of the veteran and I understand that Honor Flight San Antonio does NOT provide medical care. I understand that I accept all risks associated with travel and other Honor Flight San Antonio activities and will not hold Honor Flight San Antonio responsible for any injuries incurred by me while participating in the Honor Flight program.

Signature _____ Date _____

If the Veteran was assisted in completion of this form, please sign here and print your name, relationship and phone number:

Please sign your name: _____

Please print your name: _____

Relationship: _____ Phone number: _____

Email: _____

COVENANT NOT TO SUE AND INDEMNITY AGREEMENT

PLEASE REVIEW CAREFULLY AND SIGN

I, _____ am about to voluntarily participate in various activities, including flying activities, of the Honor Flight (TM) San Antonio. In consideration of this organization permitting me to participate in these activities, I, 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 known as The Honor Flight Network for any destruction, loss, damage or injury (including death) to my person or property which may occur from any cause whatsoever as a result of my participation in the activities of the Honor Flight (TM) San Antonio organization.

If I, my heirs, administrators, executors, or assigns should demand, claim, sue or aid in any way in such a demand, claim or suit. I agree, for myself, my heirs, administrators, executors and assigns to indemnify the Honor Flight (TM) San Antonio organization for all damages, expenses, and costs it may incur as a result thereof.

I know, understand, and agree that I am freely assuming the risk of my personal injury, death or property damage, loss or destruction that may result while participating in Honor Flight (TM) San Antonio activities, including such injuries, death, damage, loss or destruction as may be caused by the negligence of the Honor Flight (TM) San Antonio organization.

I also understand and agree that I may be held liable for any damages or loss to the Honor Flight (TM) San Antonio organization which is caused by my gross negligence, willful misconduct, dishonesty or fraud and for limited damages or loss to the Honor Flight (TM) San Antonio organization which is caused by my simple negligence.

I understand that the term Honor Flight organization includes the non-profit organization known as "Honor Flight", any officer, agent and/or employee thereof. I hereby authorize the Honor Flight Network organization, its officers, employees, members, participants, users and/ or volunteers, to take the action they believe is appropriate in an emergency situation.

Further, I agree to indemnify and hold harmless the Honor Flight San Antonio organization, any officer, employee, member, participant, user and/or volunteer thereof, against any claim(s) arising out of said emergency care.

Signature _____ Date _____

If the Veteran was assisted in completion of this form, please sign here and print your name, relationship and phone number:

Please sign your name: _____

Please print your name: _____

Relationship: _____ Phone number: _____

Email: _____

Service History

Dear veteran.

The Honor Flight San Antonio (HFSA) Board of Directors and crew have a great love of history and wish to gather and record the military histories of veterans traveling with HFSA.

Not only will this endeavor forever preserve the military history of HFSA veterans but each veteran's story, regardless of where or how you served, is unique and demonstrates the commitment and sacrifices that were made in order to protect the freedom we enjoy today. We invite you to tell us about your service. Please feel free to add additional pages; the more details you provide, the better!

We also request that you submit a copy of your SB-52 or DD-214, a completed "Military Service History" form (below), and a photograph of you in uniform (if possible) so that we might share the information with our many followers. If you no longer have a photo of you in uniform a current photo will suffice.

To help with accuracy, please try to write as clearly as possible; you might enlist the help of family and friends.

Thank you for your time.

Regards,

Honor Flight San Antonio Board of Directors

Military Service History

Please feel free to add additional pages!

Name _____ Phone Number _____

BRANCH/ES OF SERVICES: _____

Why did you pick the service branch you joined? _____

Induction date: _____ - ____ -19 ____ Discharge Date: _____ - ____ -19 ____

Rank at Completion of Service: _____

Activity during war: Theatre of operation, Unit, Division, Battalion, Ship, Plane, etc.

What was your job or assignment in the military? _____

What was your most memorable war experience/s? _____

How did your military service affect your life: your outlook, your vocational choices, your maturity, etc. _____

Were you awarded any medals, honors or citations (please detail):

NOTE: Remember to mail the following requested documents:

- Application** (if submitted electronically the following must be mailed)
- Medication list (if applicable)**
- Photo (in uniform, if available)**
- Additional pages if needed.**