Veteran and Guardian Application Packet

Prefer a 1 day trip Prefer a 2 day trip No preference

This packet includes the VETERAN and GUARDIAN applications - please submit the applications together.

At this time, a **GUARDIAN* or Travel Buddy is required.** The veteran may request a friend or family member (**not including spouses**) to accompany them. **Guardians must be able-bodied and between the ages of 18 and 70.** All guardians must submit the guardian application found in this packet. If a family member or friend is not available, we will gladly provide a guardian for you.

*Guardians are responsible to pay a fee that covers their expenses for the day. This fee will be assessed prior to the flight and MUST be paid two (2) weeks before the flight. Check or credit card accepted.

If you have any questions, please contact Debbie, our Veteran and Guardian Coordinator, at buffaloniagarahonorflight@gmail.com or 716-807-1881.

Thank you!

For Buffalo Niagara Honor Flight Use Only: LAST NAME: ______________________________ Date Received: ________________

Veteran Application

Buffalo Niagara Honor Flight, Inc.
An Official Honor Flight Network Hub
P.O. Box 426 – Clarence, NY 14031 – PHONE: 716-807-1881

Buffalo Niagara Honor Flight, a hub of the National Honor Flight Network, recognizes American Veterans for their sacrifices and achievements by flying you to Washington, DC to see YOUR memorial at no cost. Top priority is given to WWII Veterans, Korean War Veterans, Vietnam Veterans and terminally ill Veterans from all wars. Veterans are taken on a first come first serve basis. For what you and your comrades have given to us, please accept this as a small token of appreciation from all of us at Buffalo Niagara Honor Flight. Each Veteran is required to have a Guardian (travel buddy) accompany them on the flight. This individual will have an important role in ensuring our Veterans have a safe, memorable and rewarding experience.

Your Information: **Name must be as it appears on your ID for airline travel (License, Passport)**

First ______________________ Middle _______________ Last ____

First Name or Nickname to be used on Name Tag ____

Address ____

City ______________________ State ________Zip _________________ County _______________________

Phone _________________________ Cell ____________________________

Email Address ____

Weight __________ Birthday Month/Day/Year ___________________ Age ________Gender _____________

Polo Shirt Size (Check One) S M L XL 2XL 3XL

Service History

World War II Korean War Vietnam War Other ______________________

Dates of Service: From: __________________To: _________________

Branch of Service: Air Force Army Coast Guard Marines Merchant Marines Navy

Tell us about your time… Medals, ships, planes and battles (use back of sheet if needed)

Purple Heart Recipient?

Any other medals awarded? ____

____

Rank at discharge? ____

____

Where did you serve? ____

____

Activity during the War? ____

____

A GUARDIAN* (Travel Buddy) is required for all Veterans. The veteran may request a friend or family member (**not including spouses**) to accompany them. Guardians **must be able-bodied and between the ages of 18 and 70**. All guardians must submit the Guardian application found in this packet. If a family member or friend is not available, we will gladly provide a guardian for you.

* Guardians are responsible to pay a fee that covers their expenses for the day. The amount will be assessed prior to the flight and MUST be paid two (2) weeks before the flight. Check or credit card accepted.

Guardian's Name (First & Last)	Phone
Relationship to Veteran	Cell
Address	DOB

VETERANS WISHING TO FLY TOGETHER If you wish to experience this trip with another veteran who served during the same era, please list his/her name and phone number. He/she must submit a completed Veteran and Guardian Application Packet which can be downloaded from our website or we can mail the packet to them. If possible, submit all applications together to help in your request. Buffalo Niagara Honor Flight will do its best, but makes no guarantee that the veteran's request will be honored.

Veterans Name (First and Last)	Phone

Alternate Contact Information: **Provide two names that can be contacted now and on travel day.**

First ______________________________ Last ______________________________

Phone ____________________ Cell ____________________

Email Address ______________________________ Relationship ____________________

First ______________________________ Last ______________________________

Phone ________________________ Cell _________________________

Email Address ____ Relationship ___________________

This information permits assessment of support services needed during your trip.
Information is for volunteer medical, flight and administrative staff only.
Talk to your doctor about this trip!!!

YES	NO	If yes, to ANY question, it is **STRONGLY** advised that you discuss the trip with your physician!	
		Do you have a pacemaker and/or defibrillator (AICD)?	
		Do you use mobility equipment?	If yes, please check type of device(s) ___Cane ___Wheelchair ___Wheelchair confined? ___Walker ___Scooter __________________Other
		Are you able to walk, ascend, descend tour bus with assistance?	
		Do you have problems with motion sickness?	If yes, is it controlled with medications?
		Do you have balance issues or problems with being dizzy?	If yes, please describe:
		Do you have diabetes?	If yes, do you take diabetes medication? If yes, _____Injected _____Oral How often? ______________________________ .
		Do you have any dietary requirements?	If yes, please describe (e.g., vegetarian, gluten free)
		Do you have a urostomy or colostomy bag?	If yes, please specify. Please make sure the bag is vented prior to flight. Are you incontinent? ___Yes ___No
		Do you have a history of seizures? (e.g., grand mal, petit mal, other)	If yes, please describe If yes, when was your last seizure?
		Do you have any breathing problems?	If yes, please describe
		Do you use oxygen at any time?	If yes, when do you use it?
		Do you use a home nebulizer machine?	If yes, will you be able to use portable, hand-held nebulizers during the trip? ___Yes ___No
		Do you use a CPAP?	
		Do you have a history of open head injuries?	If yes, to open head injury, sinus or ear problems please answer the following: • Have you flown since the problem occurred? ___Yes ___No • If you have flown, did you have any problems? ___Yes ___No • If there were problems, please describe
		Do you have a history of sinus and/or ear problems?	
		Do you smoke?	
		Do you have any drug or food allergies?	If yes, please list
		Do you have a history of an irregular heart rate, atrial fibrillation, valve replacements, history of blood clots, high blood pressure, congestive heart failure?	If yes, please describe

PRESCRIPTION MEDICATION:

MEDICATION NAME:		TIME OF DAY:	AM PM	QUANTITY:	
Reason Medication Taken & Other Remarks:					
MEDICATION NAME:		TIME OF DAY:	AM PM	QUANTITY:	
Reason Medication Taken & Other Remarks:					
MEDICATION NAME:		TIME OF DAY:	AM PM	QUANTITY:	
Reason Medication Taken & Other Remarks:					

IF YOU HAVE MORE MEDICATIONS, PLEASE LIST ON A 8.5 X 11 SHEET OF PAPER ADD ATTACH TO APPLICATION

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

2 I further understand that Honor Flight/Buffalo Niagara Honor Flight does not provide medical care. I understand that I accept any risks associated with travel and other Honor Flight activities and will not hold Honor Flight/ Buffalo Niagara Honor Flight responsible for any injuries incurred by me while participating in the Honor Flight/Buffalo Niagara Honor Flight program.

3 Your signature on this page grants us the right to share your information with our volunteer medical, flight and administrative staff.

4. I authorize Buffalo Niagara Honor Flight officials to release my contact information (home phone and address) to other requesting individuals in the same flight for purposes of communication and camaraderie with the other participants.

NAME PRINTED ___________________________ SIGNED ____________________________________

DATE: _____________

Please submit this form to:
Buffalo Niagara Honor Flight
Veteran and Guardian Coordinator
PO Box 426
Clarence, NY 14031

For questions, please contact Debbie, our Veteran and Guardian Coordinator at:
Buffaloniagarahonorflight@gmail.com or
716-807-1881

Updated 2-21-2023

For Buffalo Niagara Honor Flight Use Only: LAST NAME: ______________________________ Date Received: ________________

Guardian Application

Buffalo Niagara Honor Flight, Inc.
An Official Honor Flight Network Hub
P.O. Box 426 – Clarence, NY 14031 – PHONE: 716-807-1881

Buffalo Niagara Honor Flight, a hub of the National Honor Flight Network, would not be successful without the generous support of our Guardians. Guardians play a significant role on every trip, ensuring that every Veteran has a safe and memorable experience. Duties include, but are not limited to, physically assisting the veterans at the airport, during the flight and at the Memorials. Guardians are responsible for their own expenses* (airfare, transportation, meals, etc.) The veteran may request a friend or family member (**not including spouses**) to accompany them. **Guardians must be able-bodied and between the ages of 18 and 70.**

*Guardians are responsible to pay a fee that covers their expenses for the day. The amount will be assessed prior to the flight and MUST be paid two (2) weeks before the flight. Check or credit card accepted.

Guardian Information: Name must be as it appears on your ID for airline travel (License, Passport)

First ____________________ Middle ______________ Last ____________________________________

First Name or Nickname to be used on Name Tag ____

Address ____

City ____________________ State _______ Zip ________________ County _____________________

Phone ______________________ Cell _________________________

Email Address ____

Weight _________ Birthday Month/Day/Year __________________ Age _______ Gender ____________

Polo Shirt Size (Check One) S M L XL 2XL 3XL

Request to travel with specific Veteran: Yes No If yes, please fill out the information below.

Veteran's Name (First & Last)	Phone
Your Relationship to Veteran	

If you are a Veteran: Dates of Service: From: ________________ To: ________________

Branch of Service: Air Force Army Coast Guard Marines Merchant Marines Navy

Tell us about your time... WHEN and WHERE you served

____

____

Alternate Contact Information: **Provide two names that can be contacted now and on travel day**

First ______________________________ Last ______________________________

Phone ____________________ Cell ____________________ Relationship ________________

First ______________________________ Last ______________________________

Phone ____________________ Cell ____________________ Relationship ________________

YES	NO	**PLEASE answer the following questions:** **Attach 8.5 X 11 sheet of paper if you need to provide additional information for the questions below or medications.**	
		Can you lift 100 lbs.?	
		Do you have any physical disabilities, restrictions and/or medical conditions that would limit your ability to fulfill the duties of a Guardian?	If yes, please describe:
		Do you have any medical experience? (e.g., EMT, CPR, Paramedic, Nurse, Doctor)	If yes, please describe:
		Do you have any drug or food allergies?	If yes, please list
		Do you have a history of seizures? (e.g., grand mal, petit mal, other) If within the last five years, it is STRONGLY advised you discuss this trip with your physician!	If yes, please describe If yes, when was your last seizure?

PRESCRIPTION MEDICATION:

MEDICATION NAME:		TIME OF DAY:	AM PM	QUANTITY:	
Reason Medication Taken & Other Remarks:					
MEDICATION NAME:		TIME OF DAY:	AM PM	QUANTITY:	
Reason Medication Taken & Other Remarks:					

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

2 I further understand that Honor Flight/Buffalo Niagara Honor Flight does not provide medical care. I understand that I accept any risks associated with travel and other Honor Flight activities and will not hold Honor Flight/Buffalo Niagara Honor Flight responsible for any injuries incurred by me while participating in the Honor Flight/Buffalo Niagara Honor Flight program.

3 Your signature on this page grants us the right to share your information with our volunteer medical, flight and administrative staff.

4. I authorize Buffalo Niagara Honor Flight officials to release my contact information (home phone and address) to other requesting individuals in the same flight for purposes of communication and camaraderie with the other participants.

NAME PRINTED ___________________________ SIGNED ___________________________________

DATE: ____________

Please submit this form to:
Buffalo Niagara Honor Flight
Veteran and Guardian Coordinator
PO Box 426
Clarence, NY 14031

For questions, please contact Debbie, our Veteran and Guardian Coordinator at:
buffaloniagarahonorflight@gmail.com or
716-807-1881

Updated 2-21-23