

AIR FORCE YOUTH FLIGHT PROGRAM PATRON REGISTRATION

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 8013; 44 USC 3101; EO 9397

PRINCIPAL PURPOSES: To provide Youth Flight Programs with authorization for medical treatment in emergency situations; authorization for field trips; identify children and sponsor; record required immunizations; record known allergies; record income data; record special needs requirements; and record special instructions.

ROUTINE USES: Form may be furnished to civilian doctors or hospitals in course of obtaining emergency medical attention for children. Information furnished may be disclosed, upon request, to other Federal, state or local governmental agencies in the pursuit of their official duties. Finally, it may be used for other lawful purposes including law enforcement and litigation.

DISCLOSURE IS VOLUNTARY: Failure to furnish information, including SSN, will result in denial of admission of child(ren) to Youth Flight Programs. SSN is used for positive identification of individuals and records.

CHILD'S NAME		SPONSOR(Last, First, Middle Initial)				SPOUSE(Last, First, Middle Initial)				FEES	
HOME PHONE		RANK/GRADE				RANK/GRADE				DEROS/ID EXPIRES	
ADDRESS		DUTY PHONE				DUTY PHONE				BRANCH OF SERVICE	
		ORGANIZATION				EMERGENCY CONTACT				EMERGENCY PHONE	
										HOSPITAL PHONE	
MARITAL STATUS		SPONSOR'S SSN				SPOUSE'S SSN				PHYSICIAN'S NAME	

VACCINE / DATE RECEIVED	BIRTH	2 MOS	4 MOS	6 MOS	12 MOS	15 MOS	18 MOS	4-6 YRS	11-12 YRS	14-16 YRS	SEX (X One)		MALE	FEMALE	DATE OF BIRTH (Day, Month, Year)
Hepatitis B															
1st	Hep B-1										I authorize emergency treatment for the children named hereon:				
2nd															
3rd		Hep B-2	Hep B-3					Hep B							
4th															
Diphtheria-Tetanus, Pertussis															
1st											SIGNATURE				DATE (YYYYMMDD)
2nd															
3rd		DTP	DTP	DTIP	DTP			DTP OR DTAP	Td		SPECIAL INSTRUCTIONS				
4th															
5th															
6th															
H.Influenzane type b															
1st											SPECIAL NEEDS CARE /CHRONIC ILLNESSES /ALLERGIES				
2nd															
3rd		Hib	Hib	Hib	Hib										
4th															
Polio															
1st															
2nd															
3rd		OPV	OPV	OPV				OPV							
4th															
Measles, Mumps, Rubella															
1st					MMR			MMR OR MMR							
2nd															
Varicella Zoster Virus Vaccine															
1st						VZV			VZV						
2nd															
OTHER IMMUNIZATIONS AS REQUIRED:															
VACCINE TYPE:		DATE:		NAMES OF ADDITIONAL CHILDREN ENROLLED IN PROGRAM:											
VACCINE TYPE:		DATE:													
VACCINE TYPE:		DATE:													
VACCINE TYPE:		DATE:													
FAMILY INCOME(Adjusted gross--most recent 1040)															
PROVIDE ONLY IF REDUCED FEES ARE REQUESTED.															
\$ _____ SINGLE / DUAL INCOME (Circle One) \$ _____															
PARENT SIGNATURE															
ADULTS AUTHORIZED TO SIGN CHILDREN IN / OUT															
AUTHORIZATION FOR FIELD TRIPS															
IT IS THE RESPONSIBILITY OF EACH SPONSOR TO ENSURE IMMUNIZATIONS AND EMERGENCY INFORMATION IS UP TO DATE. FAILURE TO UPDATE MAY RESULT IN REFUSAL OF SERVICE.															