

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							
MARITAL STATUS		SPONSOR'S SSN				SPOUSE'S SSN				HOSPITAL PHONE							
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												I authorize emergency treatment for the children named hereon:					
1st	Hep B-1																
2nd																	
3rd		Hep B-2		Hep B-3						Hep B							
Diphtheria-Tetanus, Pertussis												SIGNATURE		DATE (YYYYMMDD)			
1st												SPECIAL INSTRUCTIONS					
2nd																	
3rd		DTP	DTP	DTIP	DTP				DTP OR DTAP	Td							
4th																	
5th																	
6th																	
H. Influenzae type b												SPECIAL NEEDS CARE / CHRONIC ILLNESSES / ALLERGIES					
1st																	
2nd																	
3rd		Hib	Hib	Hib	Hib												
4th																	
Polio												SPECIAL NEEDS CARE / CHRONIC ILLNESSES / ALLERGIES					
1st																	
2nd																	
3rd		OPV	OPV	OPV					OPV								
4th																	
Measles, Mumps, Rubella												SPECIAL NEEDS CARE / CHRONIC ILLNESSES / ALLERGIES					
1st					MMR				MMR OR MMR								
2nd																	
Varicella Zoster Virus Vaccine												SPECIAL NEEDS CARE / CHRONIC ILLNESSES / ALLERGIES					
1st					VZV				VZV								
2nd																	
OTHER IMMUNIZATIONS AS REQUIRED:					NAMES OF ADDITIONAL CHILDREN ENROLLED IN PROGRAM:					ADULTS AUTHORIZED TO SIGN CHILDREN IN / OUT							
VACCINE TYPE:		DATE:															
VACCINE TYPE:		DATE:															
VACCINE TYPE:		DATE:															
FAMILY INCOME (Adjusted gross--most recent 1040)												AUTHORIZATION FOR FIELD TRIPS					
PROVIDE ONLY IF REDUCED FEES ARE REQUESTED. \$ _____ SINGLE / DUAL INCOME (Circle One) \$ _____																	
PARENT SIGNATURE												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.					