

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)	DATE OF BIRTH (Day, Month, Year)			
												MALE	FEMALE		
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						
4th															
Diphtheria-Tetanus, Pertussis												SIGNATURE _____ DATE (YYYYMMDD) _____			
1st															
2nd															
3rd		DTP	DTP	DTIP	DTP			DTP OR DTAP	Td						
4th															
5th															
6th															
H.Influenzane type b												SPECIAL INSTRUCTIONS			
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															
1st					MMR			MMR OR MMR							
2nd															
Varicella Zoster Virus Vaccine															
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): PROVIDE ONLY IF REDUCED FEES ARE REQUESTED.					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.					
\$ _____	SINGLE / DUAL INCOME (Circle One)			\$ _____											
PARENT SIGNATURE _____															