

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	8 MOS	12 MOS	15 MOS	18 MOS	4-6 YRS	11-12 YRS	14-18 YRS	SEX (X One)	DATE OF BIRTH (Day, Month, Year)	
												MALE	FEMALE

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
2nd													SPECIAL INSTRUCTIONS	
3rd		DTP	DTP	DTIP	DTP			DTP OR DTAP	Td					
4th														
5th														

H. Influenzae type b	1st											SPECIAL NEEDS CARE / CHRONIC ILLNESSES / ALLERGIES		
2nd														
3rd		Hib	Hib	Hib	Hib									
4th														

Polio	1st										SPECIAL NEEDS CARE / CHRONIC ILLNESSES / ALLERGIES		
2nd													
3rd		OPV	OPV	OPV				OPV					
4th													

Measles, Mumps, Rubella	1st										SPECIAL NEEDS CARE / CHRONIC ILLNESSES / ALLERGIES		
2nd													

Varicella Zoster Virus Vaccine	1st										SPECIAL NEEDS CARE / CHRONIC ILLNESSES / ALLERGIES		
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: _____		
VACCINE TYPE: _____ DATE: _____		

FAMILY INCOME (Adjusted gross-most recent 1040): PROVIDE ONLY IF REDUCED FEES ARE REQUESTED. \$ _____ SINGLE / DUAL INCOME (Circle One) \$ _____	AUTHORIZATION FOR FIELD TRIPS
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.