

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)	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				
Diphtheria-Tetanus, Pertussis														SIGNATURE _____ DATE _____ SPECIAL INSTRUCTIONS _____
1st														
2nd														
3rd		DTP	DTP	DTIP	DTP			DTP OR DTAP		Td				
4th														
5th														
H. Influenzae type b														SPECIAL NEEDS CARE /CHRONIC ILLNESSES /ALLERGIES
1st														
2nd														
3rd		Hib	Hib	Hib	Hib									
Polio														SPECIAL NEEDS CARE /CHRONIC ILLNESSES /ALLERGIES
1st														
2nd														
3rd		OPV	OPV		OPV			OPV						
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: _____		
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 CARE.
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