

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