# 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 NAME | EMERGENCY PHONE |
| MARITAL STATUS | SPONSOR'S SSN LAST 4 | SPOUSE'S SSN LAST 4 | 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 |
|---|---|---|---|---|---|---|---|---|---|---|
| Hepatitis B | | | | | | | | | | |
| 1st | Hep B-1 | | | | | | | | | |
| 2nd | | | | | | | | | | |
| 3rd | | Hep B-2 | | Hep B-3 | | | | | Hep B | |
| 4th | | | | | | | | | | |
| Diphtheria-Tetanus, Pertussis | | | | | | | | | | |
| 1st | | | | | | | | | | |
| 2nd | | | | | | | | | | |
| 3rd | | DTP | DTP | DTIP | DTP | | | DTP OR DTAP | Td | |
| 4th | | | | | | | | | | |
| 5th | | | | | | | | | | |
| 6th | | | | | | | | | | |
| H.Influenzane type b | | | | | | | | | | |
| 1st | | | | | | | | | | |
| 2nd | | | | | | | | | | |
| 3rd | | Hib | Hib | Hib | Hib | | | | | |
| 4th | | | | | | | | | | |
| Polio | | | | | | | | | | |
| 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 | | | | | | | | | | |

SEX *(X One)* ☐ MALE ☐ FEMALE

DATE OF BIRTH (Day, Month, Year)

I authorize emergency treatment for the children named hereon:

SIGNATURE

DATE (YYYYMMDD)

SPECIAL INSTRUCTIONS

SPECIAL NEEDS CARE /CHRONIC ILLNESSES /ALLERGIES

OTHER IMMUNIZATIONS AS REQUIRED:

| VACCINE TYPE: | | DATE: | |
|---|---|---|---|
| VACCINE TYPE: | | DATE: | |
| VACCINE TYPE: | | DATE: | |
| VACCINE TYPE: | | DATE: | |

NAMES OF ADDITIONAL CHILDREN ENROLLED IN PROGRAM:

ADULTS AUTHORIZED TO SIGN CHILDREN IN / OUT

AUTHORIZATION FOR FIELD TRIPS

FAMILY INCOME *(Adjusted gross--most recent 1040)*:
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.