

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									
		SPONSOR'S SSN				SPOUSE'S SSN				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)	MALE	DATE OF BIRTH (Day, Month, Year)					
Hepatitis B													FEMALE						
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												SIGNATURE		DATE (YYYYMMDD)					
1st												SPECIAL INSTRUCTIONS							
2nd																			
3rd			DTP	DTP	DTIP	DTP			DTP OR DTAP	Td									
4th																			
5th																			
6th																			
H. Influenzae type b																			
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							
\$ _____						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.							