

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						
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)		
													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 (YYYYMMDD)		
1st												SPECIAL INSTRUCTIONS				
2nd																
3rd		DTP	DTP	DTIP	DTP				DTP OR DTAP	Td						
4th																
5th																
6th																
H. Influenzae type b												SPECIAL NEEDS CARE /CHRONIC ILLNESSES /ALLERGIES				
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												SPECIAL NEEDS CARE /CHRONIC ILLNESSES /ALLERGIES				
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.						