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
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	DATE OF BIRTH (Day, Month, Year)
		FEMALE	

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.