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
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	DTP	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

FAMILY INCOME*(Adjusted gross--most recent 1040)*
PROVIDE ONLY IF REDUCED FEES ARE REQUESTED.
$_____ SINGLE / DUAL INCOME *(Circle One)* $_____

AUTHORIZATION FOR FIELD TRIPS

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.