

**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 SERVICES
	ORGANIZATION	EMERGENCY CONTACT	EMERGENCY PHONE
	MARITAL STATUS	SPONSOR'S SSN N/A	SPOUSE'S SSN N/A
			HOSPITAL PHONE
			PHYSICIAN'S NAME

VACCINE / DATE RECEIVED	BIRTH	2 MOS	4 MOS	6 MOS	12 MOS	15 MOS	18 MOS	4-6 MOS	11-12 MOS	14-16 MOS	SEX (X One)	MALE	FEMALE	DATE OF BIRTH (Day, Month, Year)
Hepatitis B 1st	Hep B-1													I authorize emergency treatment for the children named hereon:
2nd														
3rd	Hep B-2		Hep B-2						Hep B					
4th														
Diphtheria-Tetanus, Pertussis 1st														SIGNATURE
2nd														DATE (YYYYMMDD)
3rd		DTP	DTP	DTP	DTP				DTP OR DTAP	Td				SPECIAL INSTRUCTIONS
4th														
5th														
6th														
H. Influenzane type b 1st														SPECIAL NEEDS CARE /CHRONIC ILLNESSES /ALLERGIES
2nd														
3rd		Hib	Hib	Hib	Hib									
4th														
Polio 1st														ADULTS AUTHORIZED TO SIGN CHILDREN IN / OUT
2nd														
3rd		OPV	OPV	OPV					OPV					
4th														
Measles, Mumps, Rubella 1st					MMR				MMR OR MMR					AUTHORIZED FOR FIELD TRIPS ( SIGNATURE)
2nd														
Varicella Zoster Virus Vaccine 1st						VZV				VZV				
2nd														

OTHER IMMUNIZATIONS AS REQUIRED:	NAMES OF ADDITIONAL CHILDREN ENROLLED IN PROGRAM:	AUTHORIZED FOR FIELD TRIPS ( SIGNATURE)
VACCINE TYPE: DATE:		
VACCINE TYPE: DATE:		
VACCINE TYPE: DATE:		

FAMILY INCOME (Adjusted gross—most recent 1040) : PROVIDE ONLY IF REDUCED FEES ARE REQUESTED. \$ SINGLE / DUAL INCOME (Circle One) \$	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.
PARENT SIGNATURE	