



# MEDICAL FORM

\_\_\_\_\_  
FIRST NAME

\_\_\_\_\_  
MIDDLE NAME

\_\_\_\_\_  
LAST NAME

This information is necessary so that we may provide you with appropriate medical support during your trip. This information is for the Honor Flight medical team only and will remain confidential. Your responses to these questions will not affect your eligibility. Please fill out this page completely. If something does not apply to you, please write N/A or NONE. **Do not leave any questions blank.**

List any **drug allergies**:

What type of reaction for each individual drug?

\_\_\_\_\_  
\_\_\_\_\_

List any **food allergies**:

What type of reaction for each individual food?

\_\_\_\_\_  
\_\_\_\_\_

Do you use **OXYGEN**? YES or NO      If yes, how many liters? \_\_\_\_\_

How often? (circle one)      Continuous      With activity only      At night only      With CPAP

\*If you use oxygen, a medical team member will be in contact with you.

Do you use a **NEBULIZER** for breathing problems? YES or NO      (you may bring this with you)

Do you have **CONGESTIVE HEART FAILURE**? YES or NO

Do you have **PACEMAKER/DEFIBRILLATOR**? YES or NO

Do you have **DIABETES**? YES or NO      Do you use (circle): PILLS      INSULIN      NOTHING

Do you have **SEIZURES**? YES or NO      If yes, a member of our medical team will contact you.

Do you have a history of **OPEN HEAD INJURIES**? YES or NO

Do you have **EAR PROBLEMS**? YES or NO

Do you have **GLAUCOMA** or **ELEVATED EYE PRESSURE**? YES or NO

If yes to any of these, please describe:

\_\_\_\_\_  
Do you have any other medical conditions we should be aware of?

\_\_\_\_\_  
Do you think you may need a wheelchair for this trip for any amount of time? YES or NO

\*Walkers or motorized scooters are not allowed. Canes ARE allowed. We will gladly provide you with a wheelchair for any amount of time you need it.



# MEDICAL FORM

Do you have a **Living Will/Advanced Directive**? If yes, submit ONE copy with this application

## EMERGENCY CONTACT

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Day: \_\_\_\_\_ Evening: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_

## ALTERNATE CONTACT INFORMATION (different from your emergency contact above)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Day: \_\_\_\_\_ Evening: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_

## MEDICATIONS-Please list

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Western ND Honor Flight  
P.O. Box 265  
Bismarck, ND 58502  
Email: [info@westernndhf.org](mailto:info@westernndhf.org)  
Phone: 701-220-1568