

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.

CHILD'S NAME 1	SPONSOR (Last, First, Middle Initial) 5	SPOUSE (Last, First, Middle Initial) 10	FEEES 15
HOME PHONE 2	RANK/GRADE 6	RANK/GRADE 11	DEROS/ID EXPIRES 16
ADDRESS 3 (physical address)	DUTY PHONE 7	DUTY PHONE 12	BRANCH OF SERVICES 17
	ORGANIZATION 8	EMERGENCY CONTACT 13 (Name. This person's phone number in block 18)	EMERGENCY PHONE 18
MARITAL STATUS 4	SPONSOR'S SSN 9 (only last four)	SPOUSE'S SSN 14 (only last four)	HOSPITAL PHONE 19
			PHYSICIAN'S NAME 20

VACCINE / DATE RECEIVED	BIRTH	2	4	6	12	15	18	4-6	11-12	14-16	SEX (X One) 21	DATE OF BIRTH (Day, Month, Year) 22		
		MOS	MO S	MOS	MOS	MOS	MOS	YR	YR	YR		MALE	FEMALE	
Hepatitis B 1st		Hep B-1										I authorize emergency treatment for the children named hereon: 23 (Child's full legal name: First, middle, and last name)		
2nd											SIGNATURE 24			DATE (YYYYMMDD) 25
3rd		Hep B-2	Hep B-2					Hep B						
4th											SPECIAL INSTRUCTIONS 26			
Diphtheria-Tetanus, Pertussis 1st					DTP			DTP OR DTAP	Td					
2nd														
3rd		DTP	DTP	DTP	DTP									
4th														
5th														
6th														
H. Influenzae type b 1st											SPECIAL NEEDS CARE /CHRONIC ILLNESSES /ALLERGIES 27			
2nd		Hib	Hib	Hib	Hib									
3rd														
4th														
Polio 1st											ADULTS AUTHORIZED TO SIGN CHILDREN IN / OUT 28			
2nd														
3rd		OPV	OPV	OPV				OPV						
4th														
Measles, Mumps, Rubella 1st					MMR			MMR OR MMR			AUTHORIZED FOR FIELD TRIPS 30			
2nd														
Varicella Zoster Virus Vaccine 1st						VZV			VZV		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.			
2nd														
OTHER IMMUNIZATIONS AS REQUIRED:													NAMES OF ADDITIONAL CHILDREN ENROLLED IN PROGRAM: 29	
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 31													

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Parent's Email: _____
Parent's Email: _____

Parent Cell #1: _____
Parent Cell # 2: _____

**AF Form 1181, Air Force Youth Flight Program Patron Registration
Instructions**

One form per child – must be updated every 12 months

1. CHILD'S NAME	Child's name – Last name, First name, Middle initial
2. HOME PHONE	If family does not have a land line, cell number must be listed.
3. ADDRESS	Sponsor's physical home address, include street number, city, and zip code
4. MARITAL STATUS	Sponsor's marital status (married, single, separated, divorced, widowed, or widower)
5. SPONSOR NAME	Sponsor's name – Last name, First name, Middle initial
6. SPONSOR RANK/ GRADE	Sponsor's Rank & Grade (DOD civilian use pay grade ie: GS-06, NF-II)
7. SPONSOR'S DUTY PHONE	Sponsor's duty/work phone. Personal cell phones or home phone number not permitted.
8. SPONSOR'S ORGANIZATION	Unit/ Organization of the sponsor
9. SPONSOR'S SSN	Sponsor's LAST 4 of SSN (XXXX) last four required only
10. SPOUSE'S NAME	Spouse, if applicable – Last name, First Name, Middle initial Spouse, if not applicable – write NA
11. SPOUSE'S RANK/ GRADE	Spouse's Rank & Grade (if DOD civilian, use pay grade ie: GS-06, NF-II etc. Non-DOD may write "Other")
12. SPOUSE'S DUTY PHONE	Spouse's duty/work phone, if applicable – if not applicable, write NA
13. EMERGENCY CONTACT	Name of child's emergency contact – First name, Last name The emergency contact must be an adult in the local area and cannot be a parent. Name of emergency contact must also be listed in block 27 (Adults Authorized to Sign Children In/Out) List this person's phone number in block 18
14. SPOUSE'S SSN	If applicable, Spouses LAST 4 of SSN (XXXX) last four required only
15. FEES	For Program Use: Amount of weekly fee
16. DEROS/ ID EXPIRES	Sponsor's – DEROS/ ID Expires (DD-MM-YYYY)
17. BRANCH OF SERVICE	Branch of service for sponsor
18. EMERGENCY PHONE	Phone number for adult listed in blocks 13 and 27
19. HOSPITAL PHONE	Telephone number to the hospital or medical treatment facility where the child would be taken for treatment (LRMC Information Desk #: 486-8106)
20. PHYSICIAN'S NAME	Name of child's physician (First Name, Last Name). If PCM unknown, indicate clinic name (Ram. Peds, LRMC, etc)
21. SEX (X One)	Indicate child's sex by marking X in appropriate box (male or female)
22. DATE OF BIRTH (Day, Month, Year)	Child's date of birth (DD-MM-YYYY)
23. I authorize emergency treatment for the children named hereon:	Print the child's full legal name – First name, Middle name, and Last Name
24. SIGNATURE	Signature of child's sponsor/ spouse (or guardian)
25. DATE (YYYYMMDD)	Date form is completed (YYYY-MM-DD)
26. SPECIAL INSTRUCTIONS	Special instructions (if needed) ex: "Uses inhaler as needed" "No dairy". If not applicable, write NA
27. SPECIAL NEEDS CARE	Special needs care/ chronic illnesses/ allergies – any conditions identified on Child Placement Questionnaire must also be listed here. If not applicable, write NA
28. ADULTS AUTHORIZED TO SIGN CHILDREN IN/OUT	List all (to include Emergency Contact listed in block 13) persons authorized to sign child in/out of program (First Name, Last Name; must be aged 14+) – Parents do not need to list themselves.
29. NAMES OF ADDITIONAL CHILDREN ENROLLED IN PROGRAM	List sponsor's/ spouse's other children enrolled in CDC or SAP program. (First name, Last name)
30. AUTHORIZATION FOR FIELD TRIPS	Signature of Sponsor/ spouse (or guardian)
31. PARENT SIGNATURE	Signature of Sponsor/ parent (or guardian)
32. SPONSOR & SPOUSE'S EMAIL AND CELL NUMBERS	Sponsor & Spouse's email and cell phone numbers