sunwing

Medical Information Form for Air Travel

Please write in capital letters using black ink. Incomplete forms will be returned and may cause a delay in the process. For all dates, please use the following format: DD MMM YYYY ex: 15 JUL 2021

Passenger Details

Full Name: _____ Age: _____ ☐ Yrs ☐ Mos

Height: _____ Weight: _____ ☐ lbs ☐ kg Gender: ☐ M ☐ F

PART 1 – TO BE COMPLETED BY PASSENGER OR AGENT

Proposed Itinerary – Routing From: _____

To: _____ Flight Number: _____ Cabin: _____ Date: _____

To: _____ Flight Number: _____ Cabin: _____ Date: _____

To: _____ Flight Number: _____ Cabin: _____ Date: _____

Nature of Disability, Illness, Injury, or Diagnosis: _____

_____

Intended Travel Companion: ☐ Yes ☐ No Name: _____

Is the intended companion capable and prepared to provide all assistance including: feeding, toileting, mobility (lifting) as required? ☐ Yes ☐ No

Wheelchair – Wheelchair needed? ☐ Yes ☐ No

Other Ground Requirements Needed? ☐ Yes ☐ No

If yes, specify below and indicate against each item: (a) the arranging airline or other organisation, (b) contact addresses/phones/emails where appropriate, or whenever specific persons are designated to meet/assist the passenger.

At airport of departure? ☐ Yes ☐ No Specify: _____

While in the airport? ☐ Yes ☐ No Specify: _____

At connecting points? ☐ Yes ☐ No Specify: _____

At airport of arrival? ☐ Yes ☐ No Specify: _____

Other requirements or relevant information. ☐ Yes ☐ No Specify: _____

Specific In-Flight Arrangements Needed: ☐ Yes ☐ No

If yes, describe: _____

Provision of specific equipment, such as oxygen etc. always requires completion of Part 2.

Passenger's Declaration

"I hereby authorize _____ (Name of nominated medical doctor in capital letters) to provide (Airline Name) with the information required by the airline's Medical Provider for the purpose of determining my fitness to fly by air and in consideration thereof, I hereby agree to meet such doctor's fees in connection therewith. I take note that, if acceptable for carriage, my journey will be subject to the general conditions of carriage/tariffs of the carrier concerned and that the carrier does not assume any special liability exceeding those conditions/tariffs. I am prepared, at my own risk, to bear any consequences which carriage by air may have for my state of health and I release the carrier, its employees, servants and agents from any liability for such consequences.

I hereby authorize _____ (Airline Name) to send a copy of this authorisation to my medical doctor indicating my consent. (Where needed, to be read by/to the passenger, dated and signed by him/her, or on his/her behalf)."

Passenger's Signature: _____ Date: _____

If your medical condition/travel details change in any way prior to travelling, you are requested to contact MedAire.

PART 2 – TO BE COMPLETED BY ATTENDING PHYSICIAN

Attending Physician Contact Information – Name: _____

Telephone (Indicate country and area code): _____ Email: _____

Diagnosis / Medical Details: _____

_____

_____

_____

Date of Surgery(s) / Procedure(s): _____

Other Medical Information

Other underlying medical conditions? ☐ Yes ☐ No Specify: _____

Prognosis for Flight: ☐ Good ☐ Poor

Is Passenger free from contagious and/or Communicable Disease? ☐ Yes ☐ No

If no, specify: _____

Would the physical and/or mental condition of the passenger cause distress or discomfort to other passengers? ☐ Yes ☐ No

Will a 25% to 30% reduction in ambient partial pressure of oxygen (relative hypoxia) affect the passenger's medical condition? ☐ Yes ☐ No

(Cabin pressure is equivalent of a fast trip to a mountain elevation of 2.400 meters (8,000 feet) above sea level).

Additional Clinical Information: _____

Anaemia:? ☐ Yes ☐ No If yes, give recent hemoglobin results in g/dL: _____

Has the patient's condition deteriorated recently? ☐ Yes ☐ No

Can the patient walk 50 metres at a normal pace, or climb 10-12 stairs without symptoms? ☐ Yes ☐ No

Has the patient ever taken a commercial flight in his/her current medical status? ☐ Yes ☐ No If yes, when? _____

Did the patient have any problems? ☐ Yes ☐ No If yes, specify: _____

PART 2 – TO BE COMPLETED BY ATTENDING PHYSICIAN (next)

Oxygen / Respiratory / Portable Oxygen Concentrator
Does the passenger have an underlying respiratory disease? ☐ Yes ☐ No

SpO_2 on room air (if on O_2, please indicate rate) and date taken: _____

Does the passenger require oxygen at Home? ☐ Yes ☐ No If yes, specify how much/duration: _____

Does the passenger require oxygen in the aircraft at all time on the ground at the airport, taxi, take-off, landing & Inflight? ☐ Yes ☐ No

If yes, specify: ☐ 2 LPM ☐ 4 LPM ☐ Continuous ☐ Standby ☐ Other:

Please specify the portion of the trip requiring oxygen: _____

Specify the type of the Portable Oxygen Concentrator (POC) used: _____

Does the passenger using the POC have the physical and cognitive ability to see, hear and understand the device's aural and visual cautions/warning and responds accordingly without assistance? ☐ Yes ☐ No

If not, the user must travel with a companion who can perform these functions on their behalf.

Has the passenger had recent Arterial Blood Gases (ABG)? ☐ Yes ☐ No If yes, ABG results? _____

Blood Gases were taken on: ☐ Room Air ☐ Oxygen Litres per minute(LPM): _____

pCO2 (kPa/mm Hg) % Saturation _____ kPa/mm Hg _____ Date of Test: _____

Does the passenger retain CO_2? ☐ Yes ☐ No

Have they had a Simulated Altitude Test or Hypoxic Challenge Test? ☐ Yes ☐ No

Date of Test: _____ Results: _____

Cardiac Conditions ☐ Yes ☐ No

Angina ☐ Yes ☐ No Is the condition stable? ☐ Yes ☐ No

Functional Class of the patient? ☐ No Symptoms ☐ Angina with Minimal Exertion ☐ Angina with Moderate Exertion ☐ Angina at Rest

Myocardial Infarction? ☐ Yes No If yes, date: _____

Angioplasty or Coronary Bypass: ☐ Yes ☐ No If yes, date: _____

Complications? ☐ Yes ☐ No If yes, give details: _____

Stress ECG Done? ☐ Yes ☐ No If yes, provide results: _____

Cardiac Failure? ☐ Yes ☐ No When was last episode: _____ Is the condition Stable? ☐ Yes ☐ No

Functional Class of the Patient: ☐ No Symptoms ☐ SOB with Minimal Exertion ☐ SOB with Moderate Exertion ☐ SOB at Rest

Syncope ☐ Yes ☐ No If yes, date of last episode: _____

Investigations ☐ Yes ☐ No If yes, state results: _____

History of Seizures / Epilepsy: ☐ Yes ☐ No

Type of Seizures: _____ Are the seizures controlled by medication: ☐ Yes ☐ No

Date of Last Seizure: _____ Frequency of Seizures: _____

Behavioural / Cognitive / Psychiatric Conditions? ☐ Yes ☐ No

Is there a possibility that the patient will become agitated during the flight? ☐ Yes ☐ No

Has he/she taken a commercial flight before? ☐ Yes ☐ No If yes, Date of Travel: _____ Did the patient travel alone? ☐ Yes ☐ No

Medications and Equipment – Can these be administered independently? ☐ Yes ☐ No

Does the passenger need any medication other than self-administered and/or the use of special apparatus such as respirator, incubator, IV pump, monitor, etc.? ☐ Yes ☐ No ☐ On Ground ☐ On Aircraft Specify: _____

*Incubators are not accepted on Sunwing

List medications needed during the flight, including doses: _____

PART 2 – TO BE COMPLETED BY ATTENDING PHYSICIAN (next)

Escort – Is the passenger fit to travel unaccompanied? ☐ Yes ☐ No

Can the passenger use a normal aircraft seat with seatback placed in upright position when so required? ☐ Yes ☐ No

Traveling via Stretcher? ☐ Yes ☐ No Normal Bowel Control ☐ Yes ☐ No

*Please note Sunwing does not accept stretcher(s) may be a reason for denied travel/transportation

Normal Bladder Control ☐ Yes ☐ No If no, give method of control: _____ ☐

Can they take care of their own needs on board unassisted (including feeding, toileting, mobility etc.)? ☐ Yes No

If no, would a meet and assist (booked to embark and disembark) be sufficient? ☐ Yes ☐ No

Do they need an Escort to take care of their needs on board? ☐ Yes ☐ No

Name of Escort: _____ ☐ Doctor ☐ Nurse ☐ Paramedic ☐ Family or Other: _____

If family or other, is the escort fully capable to attend to all above needs? ☐ Yes ☐ No

Mobility – Is the passenger able to walk without assistance? ☐ Yes ☐ No

Wheelchair needed? ☐ Yes ☐ No Category: ☐ WCHR ☐ WCHS ☐ WCHC

WCHR – Require wheelchair to and from the aircraft. Passenger can ascend and descend steps and can move in the cabin.

WCHS – Require wheelchair to and from the aircraft, and must be carried up/down steps. Passenger is able to move in the cabin

WCHC – Require wheelchair to and from the aircraft, must be carried up/down steps, and to/from their seat in the cabin. Passenger is completely immobile.

Personal Wheelchair ☐ Yes ☐ No Collapsible: ☐ Yes ☐ No Dimensions W: ___ D: _____ H: _____ Weight: _____

☐ Manual ☐ Power Driven Battery Type: ☐ WCBD ☐ WCBW ☐ WCMP ☐ Lithium

Hospitalization – Does the passenger require hospitalization? ☐ Yes ☐ No

During Layover ☐ Yes ☐ No Receiving Hospital: _____

Receiving Physician: _____ Telephone Contact: _____

Upon Arrival at Destination ☐ Yes ☐ No Receiving Hospital: _____

Receiving Physician: _____ Telephone Contact: _____

Ambulance Needed? ☐ Yes ☐ No At Origination: ☐ Yes ☐ No During Layover: ☐ Yes ☐ No At Destination: ☐ Yes ☐ No

Other remarks or information in the interest of the passenger's smooth and comfortable travel.

☐ None Specify: _____

_____

Other arrangements made by the attending physician: _____

_____

Attending Physician's Signature: _____

Print Name: _____ Date: _____