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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 e.g. 15/Jul/2022

Booking Information

Passenger details	
Full name:	
Booking reference:	

Part 1 - To Be Completed By Passenger or Agent

Section 1

Proposed itinerary – routing from

To:	**Flight number:**	**Date:**
From:	**Flight number:**	**Date:**

Section 2

Nature of disability, illness, injury or diagnosis:

Section 3

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

Section 4

Wheelchair needed? ☐ Yes ☐ No

Section 5

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

If Yes, specify:

While in the airport? ☐ Yes ☐ No

If Yes, specify:

At airport of arrival? ☐ Yes ☐ No

If Yes, specify:

Other requirements or relevant information? ☐ Yes ☐ No

If Yes, specify:

Has the patient ever taken a commercial flight in their current medical status? ☐ Yes ☐ No

If Yes, specify:

Did the patient have any problems or any supplementary oxygen requirement? ☐ Yes ☐ No

If Yes, specify including dates:

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Section 5 (continued)	
	Can medications and equipment be administered independently? ☐ Yes ☐ No
	Can the patient use a normal aircraft seat with seatback placed in the upright position when so required? ☐ Yes ☐ No
	Can they take care of their own needs onboard unassisted (including feeding, toileting, mobility etc.)? ☐ Yes ☐ No
	Any other remarks or information in the interest of the patient's smooth and comfortable travel? ☐ Yes ☐ No
	If Yes, specify:

Passenger Declaration

I hereby authorise my relevant medical practitioner to provide ***Jet2.com/Jet2holidays*** with the information required by the airline's medical provider for the purpose of determining my fitness to fly by air and on consideration there of. I hereby agree to meet such doctors 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, it's employees, servants and agents from any liability for such consequences.

I hereby authorise ***Jet2.com/Jet2holidays*** to send a copy of this authorisation to my nominated medical professional indicating my consent (where needed, to be read by/to the passenger, dated by him/her, or on his/her behalf).

Passenger's signature:	**Date:**

If your medical condition/travel details change in any way you must inform Jet2.com/Jet2holidays.

Travel Insurance - It is highly recommended that all customers have sufficient travel insurance cover in place, valid for the duration of their journey, to include unscheduled flight diversions and/or early return to the UK due to their illness.
Information can be found at **www.Jet2Insurance.com**

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Part 2 – To Be Completed By Registered Medical Professional

Section 1

Passenger name:	**Height:**
Passenger age:	**Weight:**

Section 2

Diagnosis/medical history:
Date of diagnosis/injury:
Date of surgery(s)/procedure:

Section 3

Other underlying medical conditions: ☐ Yes ☐ No
Other medical information:
Anaemia: ☐ Yes ☐ No
If Yes, give recent haemoglobin results in g/dl:

Section 4

Contagious and communicable disease? ☐ Yes ☐ No
If Yes, specify:

Section 5

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

Section 6

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

Section 7

Prognosis for flight: ☐ Good ☐ Poor

Section 8

The cabin altitude is likely to be 8000 ft, therefore will a 25% to 30% reduction in ambient partial pressure of oxygen (relative hypoxia) affect the patient medical condition? ☐ Yes ☐ No
Additional Clinical Information:

Section 9

Does the patient have an underlying respiratory disease? ☐ Yes ☐ No ***If no move on to section 10***
Sp02 on room air (if on 02, please indicate rate) and date taken:
Does the patient require oxygen at home? ☐ Yes ☐ No
If Yes, specify how much/duration:
Does the patient require oxygen in-flight? ☐ Yes ☐ No
If Yes, specify: 2 litres per minute ☐ 4 litres per minute ☐ Continuous ☐ Intermittent ☐ **Other:**

Section 9 (continued)

Jet2.com is unable to supply medical breathing oxygen. Customers are required to provide their own for use onboard. The carriage of chemical oxygen generators and liquid oxygen systems is strictly prohibited.

Important: There are no charging facilities on the aircraft therefore it is the patient's responsibility to carry an adequate supply of medical breathing oxygen to cover the full duration of the flight also taking into account the possibility of a flight delay. If the patient is carrying battery powered equipment, we need to be made aware of the quantity, makes and models and number of batteries so that, in accordance with the Dangerous Goods regulations, approval can be granted for carriage. There are restrictions on the number of batteries and devices carried therefore prior approval must be sought.

Please select the type of oxygen device that will be used by the patient:

☐ **Oxygen Cylinder** (Must weigh less than 5 kg)
☐ **Portable Oxygen Concentrator (POC)**
Number of cylinder's/POC's:

Make:	**Model:**

Please state the users capability for seeing, hearing and responding to the alarms of the Portable Oxygen Concentrator:

Has the patient 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 patient retain CO2? ☐ Yes ☐ No

Have they had a simulated altitude test or hypoxic challenge test? ☐ Yes ☐ No	**Date of test:**

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

Section 10

Cardiac Conditions: ☐ Yes ☐ No ***If no move on to section 11***

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:	**If Yes, date of 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, provide results: ☐ Yes ☐ No

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Section 11	Medications and equipment
	Does the patient need any medication other than self administered, and/or the use of special apparatus such as respirator, incubator, IV pump, monitor etc. that doesn't include any oxygen equipment from sec Yes ☐ No ☐ On the ground ☐ On the aircraft ☐
	If Yes, specify:

Section 12	Escort
	Is the patient fit to travel unaccompanied? ☐ Yes ☐ No
	Do they need an escort to take care of their needs onboard? ☐ Yes ☐ No
	Name of escort:
	Doctor ☐ Nurse ☐ Paramedic ☐ Family ☐ **Other:**
	If family or other, is the escort fully capable to attend to all above needs? ☐ Yes ☐ No

MEDICAL CLEARANCE REQUESTS WILL NOT BE PROCESSED WITHOUT COMPLETION OF ALL THE DETAILS ABOVE AND BELOW OR IN EXCESS OF 30 DAYS PRIOR TO YOUR DEPARTURE DATE.

I CONFIRM THAT TO THE BEST OF MY KNOWLEDGE THIS INFORMATION IS TRUE AND COMPLETE.

Name of Practice:	**Registered Medical Professional Title:**
Registered Medical Professional's Signature:	
Date:	

Registered medical professional contact information
Full name:
Telephone number:
Email:

Registered Medical Professional Stamp: (If a stamp of the practice cannot be provided then an additional document on headed paper/ business card with the Registered Medical Professional signature must be provided)	