

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/2018

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, when?

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

If Yes, specify including dates:

Passenger Declaration

I hereby authorise _____ (name of registered medical professional) 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 thereof. 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, its 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

Part 2 – To Be Completed By Registered Medical Professional

Section 1	Registered medical professional contact information	
	Full name:	Date:
	Telephone number:	Email:
Section 2	Passenger name:	Height:
	Passenger age:	Weight:
Section 3	Diagnosis/medical history:	
	Date of diagnosis/injury:	
	Date of surgery(s)/procedure:	
Section 4	Other underlying medical conditions: Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Other medical information:	
Section 5	Prognosis for flight: Good <input type="checkbox"/> Poor <input type="checkbox"/>	
Section 6	Is patient free from contagious and/or communicable disease? Yes <input type="checkbox"/> No <input type="checkbox"/>	
	If No, specify:	
Section 7	Would the physical and/or mental state of the patient cause distress or discomfort to other passengers? Yes <input type="checkbox"/> No <input type="checkbox"/>	
	If Yes, specify:	
Section 8	Has the patient's condition deteriorated recently? Yes <input type="checkbox"/> No <input type="checkbox"/>	
	If Yes, why?	
	Can the patient walk 50 metres at a normal pace, or climb 10-12 stairs, without becoming breathless? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Section 9	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 <input type="checkbox"/> No <input type="checkbox"/>	
	Additional Clinical Information:	
	Anaemia: Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, give recent haemoglobin results in g/dl:	
Section 10	Does the patient have an underlying respiratory disease? Yes <input type="checkbox"/> No <input type="checkbox"/> , If no move on to section 11	
	SpO2 on room air (if on O2, please indicate rate) and date taken:	
	Does the patient require oxygen at home? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, specify how much/duration:	

Section 10
continued

Does the patient require oxygen in-flight? Yes <input type="checkbox"/> No <input type="checkbox"/>	
If Yes, specify: 2 litres per minute <input type="checkbox"/> 4 litres per minute <input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent <input type="checkbox"/> Other:	
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:	
<input type="checkbox"/> Oxygen Cylinder (Must weigh less than 5 kg)	
<input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/>	
If Yes, ABG results?	
Blood gases were taken on: Room Air <input type="checkbox"/> Oxygen <input type="checkbox"/> Litres per minute (LPM):	
pCO2 (kPa/mm Hg) % Saturation kPa/mm Hg)	Date of test:
Does the patient retain CO2? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Have they had a simulated altitude test or hypoxic challenge test? Yes <input type="checkbox"/> No <input type="checkbox"/>	Date of Test:

Section 11

Cardiac Conditions: Yes <input type="checkbox"/> No <input type="checkbox"/> , If no move on to section 12	
Angina? Yes <input type="checkbox"/> No <input type="checkbox"/>	Is the condition stable? Yes <input type="checkbox"/> No <input type="checkbox"/>
Functional class of the patient	
No symptoms <input type="checkbox"/> Angina with minimal exertion <input type="checkbox"/> Angina with moderate exertion <input type="checkbox"/> Angina at rest <input type="checkbox"/>	
Myocardial Infarction? Yes <input type="checkbox"/> No <input type="checkbox"/>	If Yes, date:
Angioplasty or coronary bypass: Yes <input type="checkbox"/> No <input type="checkbox"/>	If Yes, date:
Complications? Yes <input type="checkbox"/> No <input type="checkbox"/>	
If Yes, give details:	
Stress ECG done? Yes <input type="checkbox"/> No <input type="checkbox"/>	
If Yes, provide results:	
Cardiac failure Yes <input type="checkbox"/> No <input type="checkbox"/>	If Yes, when was last episode:
Is the condition stable? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Functional class of the patient:	
No symptoms <input type="checkbox"/> SOB with minimal exertion <input type="checkbox"/> SOB with moderate exertion <input type="checkbox"/> SOB at rest <input type="checkbox"/>	
Syncope Yes <input type="checkbox"/> No <input type="checkbox"/>	If Yes, date of last episode:
Investigations Yes <input type="checkbox"/> No <input type="checkbox"/>	
If Yes, state results:	

Section 12	Medications and equipment	
	Can medications and equipment be administered independently? Yes <input type="checkbox"/> No <input type="checkbox"/>	
	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 section 10? Yes <input type="checkbox"/> No <input type="checkbox"/> On the ground <input type="checkbox"/> On the aircraft <input type="checkbox"/>	
	If Yes, specify:	
Section 13	Escort	
	Is the patient fit to travel unaccompanied? Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Can the patient use a normal aircraft seat with seatback placed in the upright position when so required? Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Can they take care of their own needs onboard unassisted (including feeding, toileting, mobility etc.)? Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Do they need an escort to take care of their needs onboard? Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Name of escort: Doctor <input type="checkbox"/> Nurse <input type="checkbox"/> Paramedic <input type="checkbox"/> Family <input type="checkbox"/> Other:	
	If family or other, is the escort fully capable to attend to all above needs? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Section 14	Does the patient require hospitalisation? Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Upon arrival at destination? Yes <input type="checkbox"/> No <input type="checkbox"/>	Receiving Hospital:
	Ambulance needed? Yes <input type="checkbox"/> No <input type="checkbox"/>	
	At origination? Yes <input type="checkbox"/> No <input type="checkbox"/>	At destination? Yes <input type="checkbox"/> No <input type="checkbox"/>
Section 15	Any other remarks or information in the interest of the patient's smooth and comfortable travel? Yes <input type="checkbox"/> No <input type="checkbox"/>	
	If Yes, specify:	

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 Stamp: <i>(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)</i>			