



MEDICAL INFORMATION SHEET - MEDIF - PART 2

This form provides CONFIDENTIAL information to enable the airlines' MEDICAL Departments to assess the fitness of the passenger to travel... The PHYSICIAN ATTENDING the incapacitated passenger is requested to please ANSWER ALL QUESTIONS using BLOCK LETTERS.

Flight Nr.: _____ Date: ____/____/____ Itinerary: _____

Airlines Ref. _____

MEDA 01 PATIENT'S NAME: _____ Age: _____ Sex: _____

MEDA 02 ATTENDING PHYSICIAN Name _____ Address: _____ Telephone Contacts: _____ Business: _____ Cellphone: _____

MEDA 03 Diagnosis: _____ Date of first symptoms ____/____/____ Date of Diagnosis: ____/____/____

MEDA 4 PROGNOSIS for the trip: _____

MEDA 5 CONTAGIOUS and communicable disease? No [] Yes [] Specify: _____

MEDA 6 Is the patient's condition a source of DISCOMFORT to OTHER PASSENGERS? No [] Yes [] Specify: _____

MEDA 7 Is the patient able to SIT in the upright position? Yes [] No [] Specify: _____

MEDA 8 Can patient take care of his own needs on board UNASSISTED (including meals, visit to toilet, etc.)? Yes [] No [] If not, type of help needed: _____

MEDA 9 Is the patient's ESCORT qualified? No [] Yes [] Specify: _____

MEDA 10 Does patient need OXIGEN in flight? No [] Yes [] -> [] Liters per minute Continuous? Yes [] No []

MEDA 11 Does patient need any MEDICATION or MEDICAL EQUIPMENT in transit? No [] Yes [] Specify: _____

MEDA 12 Does patient need any medication or medical equipment on board of the AIRCRAFT? No [] Yes [] Specify: _____

MEDA 13 Does patient need HOSPITALIZATION in transit? No [] Yes [] Specify: _____

MEDA 14 Does patient need hospitalization upon arrival? No [] Yes [] Specify: _____

MEDA 15 Other REMARKS or information None [] Specify if any: _____

MEDA 16 Other arrangements made by the attending physician: _____

MEDA 17 Type of transport to / from airport: _____

Date: ____/____/____ Place: _____ Attending Physician's Signature: _____

PASSENGER'S DECLARATION "I HEREBY AUTHORIZE (name of physician) _____ to provide the airlines with the information required by those airlines' medical departments for the purpose of determining my fitness for carriage by air and in consideration thereof I hereby relieve that physician of his/her professional duty of confidentiality in respect of such information, and agree to meet such physician's fees in connection therewith. I take note that, if accepted 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 am fully aware that cabin attendants are not authorized to give special assistance to particular passengers, to the detriment of their service to other passengers. I am further aware that they are trained only in basic first aid and are not permitted to administer any injection or medication. I agree to reimburse the carrier upon demand for expenditures or costs in connection with my carriage and with any special in-flight arrangements needed". (Where needed, to be read by / to the passenger, dated and signed by him/her or on his/her behalf)

Date: ____/____/____ Place: _____ Passenger's signature: _____ (or someone on his/her behalf)