Jet2.com

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 use the following format dd/mm/yyyy.

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**

Booking Information

Full name:
***Jet2* Booking reference:**

Part 1 - To Be Completed by the Passenger

Section 1	**Outbound airport:**	**Flight number:**	**Date:**
	Inbound airport:	**Flight number:**	**Date:**

Level of Assistance Required

Section 2	**WCHR** Cannot walk far, but can manage stairs.	**WCHS** Cannot walk far. Cannot manage stairs.	**WCHC** Unable to walk or manage stairs and will need help into seat.
	DPNA Wheelchair assistance not required, additional support needed.	**Blind**	**Deaf**
	Other:		

Previous Flights

Section 3	**Has the passenger ever taken a commercial flight in their current medical status?** ☐ Yes ☐ No
	If yes, specify dates:
	Did the passenger have any problems or any supplementary oxygen requirements? ☐ Yes ☐ No
	If yes, specify dates:

Passenger Information

Section 4	**Can medication and equipment be administered/operated independently** ☐ Yes ☐ No
	Can passenger sit upright in seat for take-off and landing? ☐ Yes ☐ No
	Can passenger bend their leg? ☐ Yes ☐ No Knee bent so their feet are under the seat in front or heel on the floor, like they are sitting at a dining table.
	Can they take care of their needs on board such as toileting and feeding? ☐ Yes ☐ No
	Any other information:

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 signature:	**Date:**

Jet2.com

Part 2 – To Be Completed by Registered Medical Professional

Section 1	**Passenger name:**	**Height:**
	Passenger age:	**Weight:**

Section 2	**Diagnosis & Medical History.** If applicable please advise if local or general anaesthetic was administered during a surgery.
	Date of Diagnosis/injury:

Section 3	**Anaemia:** ☐ Yes ☐ No **If yes, give recent Haemoglobin results in g/dl:** Results must be more that 24 hours after most recent episode of blood loss. If no blood loss has occurred, the results from the most recent test will be accepted.

Section 4	**Does the passenger have any contagious or communicable disease?** ☐ Yes ☐ No
	If yes, please specify:
	Does the passenger have a Psychiatric disorder? ☐ Yes ☐ No
	If yes, please specify if they are likely to become agitated during the flight:

Prognosis for Flight

Section 5	**Prognosis for flight:** ☐ Fit to Fly ☐ Not Fit to Fly **Please note:** This must be a clear answer and is required for clearance. A remark of unsure or cannot comment will not be accepted.

Section 6	**Has the patient's condition deteriorated recently?** ☐ Yes ☐ No
	If yes, please specify:

Section 7	**The cabin altitude is likely to be 8000ft, therefore will a 25% to 30% reduction in the ambient partial pressure of oxygen (relative hypoxia) affect the patients' medical condition?** ☐ Yes ☐ No **Please note:** This must be a clear answer and is required for clearance. A remark of unsure or cannot comment will not be accepted.
	Additional Clinical information:

Jet2.com

Cardiac, Respiratory and Oxygen

Section 8

Does the patient have an underlying respiratory disease? ☐ Yes ☐ No **If no move on to section 9**

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

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 5kg)

☐ **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 9

Cardiac conditions: ☐ Yes ☐ No **If no move on to section 10**

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, specify date:**
Angioplasty or coronary bypass: ☐ Yes ☐ No	**If yes, specify date:**

Complications: ☐ Yes ☐ No

If yes, provide results:

Stress ECG done? ☐ Yes ☐ No

If yes, provide results:

Section 9 (continued)	**Cardiac failure:** ☐ Yes ☐ No	**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:	

Medications and Equipment

Section 10	**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. (not including any oxygen equipment from section 9):** ☐ Yes ☐ No ☐ On the ground ☐ On the aircraft
	If yes, specify:

Escort

Section 11	**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's title:	
Registered Medical Professional's signature:	**Date:**
Registered Medical Professional's 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).	