MEDICAL INFORMATION FORM (MEDIF) FOR AIR TRAVEL

(Made pursuant to IATA resolution 700 Attachment A)

INFORMATION SHEET FOR PASSENGER REQUIRING SPECIAL ASSISTANCE

PART 1 - TO BE COMPLETED BY THE PASSENGER

PLEASE COMPLETE THE FORM IN CAPITAL LETTERS

A	Last Name/First Name/Title	
B	Passenger Name Record (PNR)	Sex : Male [___] Female [___]
C	Proposed Travel Date …….. Route(s)…… Date…… Class of Ticket: First Class [___] Business [___] Economy [___]	
D	Nature of disability / illness / injury	
E	Stretcher needed onboard?	Yes [___] No [___]
F	Intended escorts? Yes [___] No [___] Name …… Sex : Male [___] Female [___] Age …….. Title …… …… PNR (if different from Passenger's) …… Medical Qualification ……..Language Spoken …… If untrained, state "Travel Companion." …… Is the intended escort capable and prepared to provide all assistance including feeding, toileting and lifting as required? Yes [___] No [___]	
G	Wheelchair needed?	Yes [___] No [___] If Yes, indicate type Wheelchair categories: WCHR [___] WCHS [___] WCHC [___]
	Own wheelchair?	Yes [___] No [___]
	Collapsible wheelchair:	Yes [___] No [___]
H	Will Passenger be carrying a urinary bag?	Yes [___] No [___]
I	Will passenger be carrying any other medical appliance or special apparatus such as respirator, IV pump, monitor, incubator etc?	Yes [___] No [___] If yes, please specify nature/type of medical/special apparatus …… ……
J	Other ground arrangement needed?: Yes [___] No [___] If Yes, please specify a. Arrangement at Departure airport …… b. Arrangement at Transit airport …….. c. Arrangement at Arrival airport ……	
K	Special in-flight arrangements needed: Yes [___] No [___] If Yes, please specify type of arrangement (special meal, extra seat, leg rest, special seating) Subject to availability…….. ❖ Any special in-flight arrangement will be at an additional cost to the passenger.	

WCHR=Passenger cannot walk well but can use stairs
WCHS=Passenger cannot use stair WCHC=Passenger cannot walk at all

PASSENGER DECLARATION

I hereby declare that the information supplied above is accurate.

I authorize Overland Airways to use and release this information as required in the event of an emergency.

I acknowledge that the Airline staffs are not medically trained and that the Airline cannot guarantee that I will receive appropriate medical attention in any situation.

I acknowledge that overland Airways reserves the right to refuse travel, notwithstanding completion of this form, if the Airline considers that it is not in my best interest to fly.

I hold OVERLAND AIRWAYS harmless from any liability, loss or claim in the event that I am found to be medically unfit to travel or refused clearance to be carried on board OVERLAND AIRWAYS flight.

…….. ……
Signature / Name **Date**

NOTE:
Cabin Attendants are not authorized to give special assistance (e.g. lifting) to particular passenger, to the detriment of their service to the other passengers. Additionally, they are trained only in First Aid and not permitted to administer any injection or give medication.

IMPORTANT:
Fees, if any, relevant to the provision of the special assistance will be at additional cost to the passenger concerned.

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MEDICAL INFORMATION FORM (MEDIF) FOR AIR TRAVEL

(Made pursuant to IATA resolution 700 Attachment A)

INFORMATION SHEET FOR PASSENGER REQUIRING MEDICAL CLEARANCE

PART 2 (A) - To Be Completed By the Attending Nominated Physician

This form is intended to provide CONFIDENTIAL information to assess the fitness of the passenger to travel. If the passenger can be transported, this information will facilitate the issuance of the necessary directives.

PLEASE ANSWER ALL QUESTIONS AND COMPLETE THE FORM IN CAPITAL LETTERS

1	Passenger's name: ..... Date of Birth: .....Sex: ..... Height: ..... Weight:	
2	Name of Attending physician: ..... E-mail .....Tel/Mobile..... Fax ……..….. Address: ……..	
3	Diagnosis/Medical Details: ……..…… Type Operation: ..... Date of Surgery/Procedure: (DD/MM/YY)...../...../.....	
4	Prognosis for the flight(s): BP: ……. Pulse: …… Temp: …… SA02 (on air): …… Level of Consciousness: …… Fit to Fly? Yes [__] No[__]	
5	Is the Passenger free from contagious and/or communicable diseases?	Yes [__] No[__]
6	Would the passenger's physical /mental condition cause distress or discomfort to other passengers?	Yes [__] No[__]
7	Does the passenger require Oxygen in the aircraft on the ground?	Yes [__] No[__]
8	Does the passenger require Oxygen in flight?	Yes [__] No[__]
9	Can the passenger use a normal aircraft seat, with setback placed in the UPRIGHT position when so required?	Yes [__] No[__]
10	Can the passenger take care of his/her own needs on board UNASSISTED (Including feeding, toileting, mobility etc)	Yes [__] No[__] If NO refer to Part 1 (F)
11	Does the passenger need any medication other than self administered and/or would require medical appliance/special apparatus such as respirator, incubator, IV pump, monitor, urinary bag on board the flight?	Yes [__] No[__]
	If Yes, please list the medications/special apparatus……..	

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	Can these be administered independently? Yes [__] No[__]		
12	Additional clinical information a. Anemia b. Psychiatric and seizure disorder c. Cardiac condition d. Normal bladder control e. Normal bowel control f. Respiratory condition g. Does passenger require oxygen in the aircraft on ground? h. Oxygen needed in flight?	 Yes [__] No[__] Yes [__] No[__] Yes [__] No[__] Yes [__] No[__] Yes [__] No[__] Yes [__] No[__] Yes [__] No[__]	 If yes, give recent result in grams of hemoglobin ……. If yes, see Part 2 If yes, see Part 2 If no, give mode of control …… If yes, see Part 2 If yes, specify how much If yes, specify: 2 LPM [__] 4 LPM [__] Other [__]
13	Escort a. Is the passenger fit to travel unaccompanied? b. If no, would a meet-and-assist be sufficient? c. If no, will the passenger have a private escort to take care of his/her needs onboard? d. If yes, who should escort the passenger? e. If other, is the escort fully capable to attend to all the above needs?		 Yes [__] No[__] Yes [__] No[__] Yes [__] No[__] Doctor [__] Nurse [__] Other [__] Yes [__] No[__]
14	Mobility a. is passenger able to walk without assistance b. Wheelchair required for boarding		 Yes [__] No [__] to aircraft [__] to seat [__]
15	Other medical information: ..... …… ……		

Name / Signature of Attending Physician……..…….. Date ...../……/.....

Affix Hospital Stamp

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INFORMATION SHEET FOR PASSENGER REQUIRING MEDICAL CLEARANCE

PART 2(B) - To Be Completed By the Attending Nominated Physician

PLEASE ANSWER ALL QUESTIONS AND COMPLETE THE FORM IN CAPITAL LETTERS

1	CARDIAC CONDITION	
a.	Angina If yes, When was last episode?	[___] Yes [___] No .....
	Is the condition stable?	[___] Yes [___] No
	Functional class of the patient**?**	[___] No symptoms [___] Angina with important efforts [___] Angina with light efforts [___] Angina at rest
	Can the patient walk 100 metres at a normal pace or climb 10 -12 stairs without symptoms?	[___] Yes [___] No
b.	Myocardial infarction If yes, Date	[___] Yes [___] No .....
	Complications? If yes, give details	[___] Yes [___] No .....
	Stress EKG done? If yes, what was the result?	[___] Yes [___] No ..... Metz
	If angioplasty or coronary bypass, can the patient walk 100 metres at normal pace or climb 10–12 stairs without symptoms?	[___] Yes [___] No
	Cardiac failure When was last episode?	[___] Yes [___] No .....
	Is the patient controlled with medication?	[___] Yes [___] No
	Functional class of the patient?	[___] No symptoms [___] Shortness of breath with important efforts [___] Shortness of breath with light efforts [___] Shortness of breath at rest
	Syncope Last episode	[___] Yes [___] No .....
	Investigations? If yes, state results	[___] Yes [___] No .....
2	Chronic pulmonary condition	[___] Yes [___] No
a.	Has the patient had recent arterial gases?	[___] Yes [___] No

MEDICAL INFORMATION FORM (MEDIF) FOR AIR TRAVEL

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b.	Blood gases were taken on: If yes, what were the results	[___] Room air [___] Oxygen ..... LPM ..... pCO2 ..... pO2
c.	Saturation ..... Date of examination: ...../...../.....(dd/mm/yyy)	
d.	Does the patient retain CO2?	[___] Yes [___] No
e.	Has his/her condition deteriorated recently?	[___] Yes [___] No
f.	Can the patient walk 100 metres at a normal pace or climb 10-12 stairs without symptoms?	[___] Yes [___] No
g.	Has the patient ever taken a commercial aircraft in these same conditions?	[___] Yes [___] No
	If yes when?	.....
	Did the patient have any problems?	.....
3.	Psychiatric Conditions	[___] Yes [___] No
	Is there a possibility that the patient will become agitated during flight	[___] Yes [___] No
b.	Has he/she taken a commercial aircraft before	[___] Yes [___] No
	If yes, date of travel? Did the patient travel	..... [___] alone [___] escorted?
4.	Seizure	[___] Yes [___] No
a.	What type of seizures?	.....
b.	Frequency of the seizures	.....
c.	When was the last seizure?	.....
d.	Are the seizures controlled by medication?	[___] Yes [___] No
5.	Prognosis for the trip	[___] Yes [___] No
Name / Signature of Attending Physician…….…….. Date …../……/….		

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