AURIC AIR SERVICES LTD
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MEDIF
MEDICAL INFORMATION FORM FOR AIR TRAVEL

PART 1 **To be completed by PASSENGER or AGENT**	**PLEASE WRITE CAPITAL LETTERS USING BLACK INK**

A	**PASSENGER'S FULL NAME**								
B	**PROPOSED ITINERARY** (Airline(s), flight number(s) ,route(s) , date(s) of continuous air travel)								
C	**NATURE OF DISABILITY , ILLNESS OR INJURY**								
D 1	**INTENDED ESCORT** (name, sex, age, professional qualification , flight /route if different from passenger) **- If untrained, state "TRAVEL COMPANION"**								
2	Is the intended escort capable and prepared to provide all assistance including lifting as required?	**YES** ☐ **NO** ☐							
E	**WHEEL CHAIR NEEDED?** **YES** ☐ **NO** ☐ If YES indicate category: **WCHR**: cannot walk far but can manage stairs ☐ **WCHS**: cannot walk far cannot manage stairs ☐ **WCHC**: unable to walk ☐	Own Wheelchair? **YES** ☐ **NO** ☐	Manual? **YES** ☐ **NO** ☐	Power Driven? **YES** ☐ **NO** ☐	Battery type? (Spill able?) **YES** ☐ **NO** ☐	Wheelchair weight **____ Kgs**	Wheelchair Dimensions (cm) **W**_____ **D**_____ **H**_____	Wheelchairs with spillable batteries are "restricted articles" and are permitted on passenger aircraft only under certain conditions.	
F	**AMBULANCE NEEDED?** **YES** ☐ **NO** ☐	Specify ambulance company contacts Specify destination address							
G	**OTHER GROUND ARRANGEMENTS NEEDED** **YES** ☐ **NO** ☐	If yes, SPECIFY below and indicate against each item: (a) the ARRANGING airline or other organization, (b) CONTACT address /phone where appropriate, or whenever specific persons are designated to meet/assists the passenger.							
	1. Arrangements for arrival at airport of departure	**YES** ☐ **NO** ☐	**Specific:**						
	2. Arrangements or assistance at connecting points	**YES** ☐ **NO** ☐	**Specific:**						
	3. Arrangements for meeting at airport of arrival	**YES** ☐ **NO** ☐	**Specific:**						
	4. Other requirements or relevant information	**YES** ☐ **NO** ☐	**Specific:**						
H	**SPECIFIC IN FLIGHT ARRANGEMENTS NEEDED** **YES** ☐ **NO** ☐ Requests such as seating, extra seat, extension belt, equipment, etc. (subject to availability).	If yes, DESCRIBE and indicate for each item: (a) FLIGHT ROUTE on which required, (b) airline-ARRANGED or arranging third party and (c) at whose expense. Provision of SPECIFIC EQUIPMENT , such as oxygen etc. always requires completion of PART 2 overleaf							
		(a)							
		(b)							
		(c)							

PASSENGER'S DECLARATION

(Name of nominated medical doctor in CAPITAL LETTERS)

"I HEREBY AUTHORISE .....

To provide the airline with the information required by those airlines' Medical Provider for the purpose of determining my fitness to fly by air and in consideration thereof, I hereby agree to meet such doctor's fees in connection therewith. I take note that, if accepted for the 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 agree to reimburse the carriage upon demand for any special expenditures or costs in connection with my carriage. I hereby authorize **Auric Air Tanzania Ltd**. to send a copy of this authorization to my medical doctor indicating my consent. **" (Where needed, to be read by/to the passenger , dated and signed by him/her, or on his/her behalf)**

Date (DD/MM/YY)	**Passenger's signature**	**If your medical condition/travel details change in any way prior to travelling, you are requested to contact auric air.**

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PART 2

This form is intended to provide CONFIDENTIAL information to assess the fitness of the passenger. If the passenger can be transported, this information will facilitate the issuance of the necessary directives.
To be completed by
ATTENDING PHYSICIAN/NOMINATED PHYSICIAN

The ATTENDING PHYSICIAN of the incapacited passenger is requested to **ANSWER ALL QUESTIONS. ENTER** and **"X"in** the appropriate "**Yes"** or "**No"** box and give concise answers.

PLEASE COMPLETE THE FORM IN CAPITAL LETTERS USING BLACK INK

RECORD LOCATOR NUMBER (PNR)

DATE of Travel (DD/MM/YY)

MEDA 01	**PASSENGER'S FULL NAME** **SEX: M** ☐ **F** ☐ Date Of Birth(DD/MM/YY)
MEDA 02	**ATTENDING PHYSICIAN** ..... Name, address and phone number .....
MEDA 03	**DIAGNOSIS/MEDIZAL DETAILS** ..... (e.g. types of operation) Date of surgery/procedure(DD/MM/YY) **Vital signs** BP: Pulse: Temp: SAO2 (on air) % Date taken (DD/MM/YY)
MEDA 04	Prognosis for the flight (s)
MEDA 05	Is **PASSENGER FREE FROM** contagious **AND/OR** Communicable disease? **YES** ☐ **NO** ☐ Specify:
MEDA 06	Would the physical and/or mental condition of the Passenger cause distress of discomfort to other Passenger? **YES** ☐ **NO** ☐ Specify:
MEDA 07	Can the passenger use a normal aircraft seat with Seatback placed in the Upright position when so Required? **YES** ☐ **NO** ☐ Traveling via stretch? **YES** ☐ **NO** ☐
MEDA 08	Can the passenger take care of their own needs on board **UNASSISTED** (Including mobility, etc.) **YES** ☐ **NO** ☐ **NOTE: if not refer to PART 1 (D2)**
MEDA 09	Does the passenger require **OXYGEN** in the aircraft or On Ground? **YES** ☐ **NO** ☐ **2** ☐ **or 4** ☐ Ipm Standby via pulse dose? **YES** ☐ **NO** ☐ Does the passenger require **OXYGEN** in flight? **YES** ☐ **NO** ☐ **2** ☐ **or 4** ☐ Ipm Continuous via pulse dose**?** **YES** ☐ **NO** ☐
MEDA 10	Does the passenger need any MEDICATION other than self- administered (a) On ground **YES** ☐ **NO** ☐ **S**pecify:.....
MEDA 11	and/or the use of special apparatus such as respirator, incubator, IV pump, monitor etc? (b) On board **YES** ☐ **NO** ☐ Specify: ..... List medications need during the flight: ..... Can these be administered independently? **YES** ☐ **NO** ☐
MEDA 12	Does the passenger need HOSPITALISATION? Receiving Hospital: ..... (a) During layover **YES** ☐ **NO** ☐ Telephone contact: .....
MEDA 13	(if Yes indicate Arrangements made, or if No indicate "NO ACTION TAKEN") (b) Upon arrival at DESTINATION **YES** ☐ **NO** ☐ Receiving Hospital: ..... Telephone contact: .....
MEDA 14	Other remarks or information in the interest of the Passenger's smooth and comfortable travel:
MEDA 15	Other arrangements made by the attending physician:

Date (DD/MM/YY)	**Attending physician's signature**