CLEAR FORM

flair airlines

PATIENT NAME: _____

MEDICAL ACCOMMODATION APPLICATION

PASSENGER INFORMATION

LAST NAME: _____ FIRST NAME: _____

GENDER: MALE ☐ FEMALE ☐ UNSPECIFIED ☐

EMAIL ADDRESS: _____

_____

MAILING ADDRESS

_____ _____ _____

CITY/TOWN PROVINCE POSTAL CODE

CONTACT PHONE NUMBER: _____

ALTERNATIVE CONTACT INFORMATION

LAST NAME: _____ FIRST NAME: _____

RELATIONSHIP TO PASSENGER: _____

EMAIL ADDRESS: _____

PHONE NUMBER: _____

TRAVEL INFORMATION

INTENDED DATE(S) OF TRAVEL: _____

DEPARTURE CITY: _____ ARRIVAL CITY: _____

FLIGHT NUMBER: _____

PASSENGER CONSENT AND AGREEMENT

I, _____ CONSENT AND AUTHORIZE MY TREATING MEDICAL PROFESSIONALS TO PROVIDE AND DISCUSS THE INFORMATION ON THIS FORM, OTHER MEDICAL INFORMATION, OR MY PREVIOUS TRAVEL HISTORY WITH FLAIR AIRLINES AS REQUIRED TO FACILITATE MY SAFE TRAVEL BY AIR. THIS CONSENT AND AUTHORIZATION EXTEND TO ANY MEDICAL PROFESSIONAL HOLDING INFORMATION RELEVANT TO MY ASSESSMENT BY FLAIR AIRLINES, OR ANY SUPPORT ORGANIZATION ARRANGING TRAVEL ON MY BEHALF. I CONSENT TO THE COLLECTION AND RETENTION OF THE MEDICAL INFORMATION ON THIS FORM FOR THE PURPOSE OF FACILITATING TRAVEL, WITH THE UNDERSTANDING THAT THIS MEDICAL INFORMATION WILL BE KEPT CONFIDENTIAL IN ACCORDANCE WITH FLAIR AIRLINE'S PRIVACY POLICY.

I, _____ UNDERSTAND THAT IF APPROVED, FLAIR AIRLINES WILL PROVIDE APPROPRIATE ACCOMMODATIONS TO ME. I AGREE TO PROVIDE UPDATED MEDICAL INFORMATION FOR ANY SIGNIFICANT CHANGE(S) TO MY HEALTH AND TO ABIDE BY THE TERMS OF ANY MEDICAL ACCOMMODATIONS INCLUDING PERSONAL ATTENDANT REQUIREMENTS AND RESTRICTIONS APPLICABLE TO TRAVEL COMPANIONS.

PASSENGER SIGNATURE: _____ DATE: _____

PHYSICIAN INFORMATION

PHYSICIAN NAME: _____ LICENSE NUMBER: _____

PROVINCE/COUNTRY OF REGISTRATION: _____ CITY: _____

EMAIL ADDRESS: _____ FAX NUMBER: _____

IS THIS PATIENT REGULARY UNDER YOUR CARE	YES ☐	NO ☐
ANEMIA	YES ☐	NO ☐
IF YES, PROVIDE HEMOGLOBIN: _____ DATE: _____		
REQUIRES AN ATTENDANT	YES ☐	NO ☐
REQUIRES AN EXTRA SEAT FOR OBESITY	YES ☐	NO ☐
SEVERE ALLERGIES REQUIRING A BUFFER ZONE ON BOARD	YES ☐	NO ☐
DOES THE PATIENT HAVE AN ACTIVE COMMUNICABLE DISEASE THAT CAN BE TRANSMITED OR POSE A HEALTH AND SAFETY THREAT TO OTHERS DURING TRAVEL	YES ☐	NO ☐
WILL FLYING AT ALTITUDE ABOVE SEA LEVEL (2400 m / 8000 ft) WITH A POSSIBLE 30% DECREASE IN OXYGEN AFFECT YOUR PATIENT'S MEDICAL CONDITION	YES ☐	NO ☐

IF "YES" TO ANY OF THE ABOVE, PLEASE EXPLAIN:

_____
PHYSICIAN INITIAL

PHYSICIAN INFORMATION CONT.

PROGNOSIS FOR A SAFE FLIGHT WITH NO EXTRAORDINARY MEDICAL ATTENTION — GOOD ☐ POOR ☐

IF ANY OF THE FOLLOWING APPLY:

- UNSTABLE MEDICAL CONDITION ☐
- MEDICAL CONDITION THAT MAY WORSEN IN A HYPOXIC ENVIRONMENT ☐
- MAY REQUIRE MEDICAL ASSISTANCE OR EMERGENCY MEDICAL EQUIPMENT IN FLIGHT: ☐

PHYSICIAN CONSENT

BY SIGNING THIS FORM, I UNDERSTAND THAT I AM PROVIDING INFORMATION THAT FLAIR AIRLINES WILL USE TO DETERMINE MY PATIENT'S ABILITY AND/OR ACCOMMODATIONS NEEDED TO TRAVEL SAFELY. I ACCORDINGLY CERTIFY THAT ALL OF THE INFORMATION I HAVE PROVIDED IS COMPLETE, TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

PHYSICIAN SIGNATURE: _____ DATE: _____

PHYSICIAN OFFICE STAMP:

flair airlines

PATIENT NAME: _____

DECLARATION OF MEDICAL CONDITION

DIAGNOSIS: _____

DATE OF ONSET: _____

CURRENT SYMPTOMS AND SEVERITY:

TREATMENT/PRESCRIBED MEDICATION(S):

RECENT, RELEVANT, OR PLANNED PROCEDURE, SURGERY, OR SEDATION YES ☐ NO ☐

NATURE OF PROCEDURE, SURGERY, OR SEDATION: _____ DATE: _____

CURRENTLY HOSPITALIZED YES ☐ NO ☐

IF YES, WILL BE DISCHARGED TO: HOME ☐ FACILITY ☐

DATE OF DISCHARGE: _____ HEMOGLOBIN: _____ DATE: _____

_____

PHYSICIAN INITIAL

I. ALLERGIES

COMPLETE ONLY IF YOUR PATIENT HAS A SEVERELY DEBILITATING/LIFE-THREATENING ALLERGY THAT REQUIRES A BUFFER ZONE ACCOMMODATION ON BOARD THE AIRCRAFT.

ALLERGEN: ______________________________ SYMPTOMS:
- HIVES ☐
- SNEEZING ☐
- ANAPHYLAXIS ☐
- ASTHMA ATTACK ☐

ALLERGEN: ______________________________ SYMPTOMS:
- HIVES ☐
- SNEEZING ☐
- ANAPHYLAXIS ☐
- ASTHMA ATTACK ☐

ALLERGEN: ______________________________ SYMPTOMS:
- HIVES ☐
- SNEEZING ☐
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- ASTHMA ATTACK ☐

ALLERGEN: ______________________________ SYMPTOMS:
- HIVES ☐
- SNEEZING ☐
- ANAPHYLAXIS ☐
- ASTHMA ATTACK ☐

____
PHYSICIAN INITIAL

II. PULMONARY

CONDITION TYPE: _____

DOES YOUR PATIENT HAVE SHORTNESS OF BREATH

- NO ☐
- YES, AT REST ☐
- YES, WITH LIGHT EFFORTS ☐
- YES: WITH MAJOR EFFORTS ☐

HAS YOU PATIENT DETERIORATED RECENTLY YES ☐ NO ☐

DETAILS:

OXYGEN SATURATION: _____ %L/min

CONTINOUS OXYGEN: _____

PULSE SETTING: _____

ROOM AIR: _____

DOES YOUR PATIENT USE OXYGEN AT HOME YES ☐ NO ☐

IF YES, WHAT DEVICE DOES YOUR PATIENT USE:

OXYGEN TANK YES ☐ NO ☐

FLOW RATE: _____ L/min

HOURS/DAY: _____

PERSONAL OXYGEN CONCENTRATOR YES ☐ NO ☐

CONTINOUS FLOW RATE: _____ L/min

PULSE DELIVERY SETTING: _____

HOURS/DAY: _____

_____

PHYSICIAN INITIAL

PULMONARY CONT.

WILL YOU PATIENT REQUIRE OXYGEN DURING THEIR FLIGHT YES ☐ NO ☐

MAX REQUIRED FLOW RATE DURING FLIGHT: _____ L/min

MAX PULSE DELIVERY SETTING DURING FLIGHT: _____

FLAIR AIRLINES DOES NOT SUPPLY OXYGEN FOR USE ON BOARD THE AIRCRAFT AND GASEOUS OXYGEN TANKS/CYLINDERS ARE PROHIBITED ON BOARD ALL FLAIR AIRCRAFT. PASSENGERS ARE PERMITTED TO BRING THEIR OWN PERSONAL OXYGEN CONCENTRATORS, PROVIDED THEY ARE ONE OF THE APPROVED MODELS.

PLEASE CONFIRM THAT YOUR PATIENT WILL BRING THEIR OWN PERSONAL OXYGEN CONCENTRATOR (POC) ON BOARD FOR USE DURING THEIR FLIGHT YES ☐ NO ☐

CAN YOU RPATIENT MANAGE THEIR POC DURING THEIR FLIGHT INCLUDING RESPONDING TO ALERTS AND EXCHANGING OF BATTERIES YES ☐ NO ☐

DOES YOUR PATIENT HAVE ENOUGH BATTERIES TO LAST AT LEAST 1.5 TIMES THE DURATION OF THEIR FLIGHT YES ☐ NO ☐

III. CARDIAC

CONDITION TYPE: _____

OXYGEN SATURATION: _____ %L/min CONTINOUS OXYGEN: _____

PULSE SETTING: _____ ROOM AIR: _____

ANGINA YES ☐ NO ☐

DATE: _____

YOUR PATIENT'S CONDITION IS: STABLE ☐ UNSTABLE ☐

IF UNSTABLE, PLEASE SELECT ONE:

NO SYMPTOMS ☐

ANGINA AT REST ☐

ANGINA W/ MINOR EFFORT ☐

ANGINA W/ MAJOR EFFORT ☐

_____

PHYSICIAN INITIAL

CARDIAC CONT.

MYOCARDIAL INFRACTION YES ☐ NO ☐

DATE: _____

COMPLICATIONS: STABLE ☐ UNSTABLE ☐

ANGIOGRAM/ANGIOPLASTY/BYPASS YES ☐ NO ☐

PROCEDURE DATE: _____

ANGIOGRAM ☐ ANGIOPLASTY ☐ BYPASS ☐

CARDIAC FAILURE YES ☐ NO ☐

FUNCTIONAL CLASS (1 - 4) : _____

DETAILS:

SYNCOPE YES ☐ NO ☐

DATE OF LAST EPISODE: _____

INVESTIGATION YES ☐ NO ☐ UNDIAGNOSED ☐

IF INVESTIGATED, RESULT/CAUSE:

_____

PHYSICIAN INITIAL

IV. SEIZURES

TYPE: _____

FREQUENCY: _____ **DURATION:** _____

DATE OF LAST SEIZURE: _____ **DATE OF LAST HOSPITAL VISIT DUE TO SEIZURE:** _____

ARE THE SEIZURES CONTROLLED BY MEDICATION YES ☐ NO ☐

IS OXYGEN OR SUCTION REQUIRED TO MANAGE THE SEIZURE YES ☐ NO ☐

WHAT ACTIONS ARE TAKEN TO MANAGE THE SEIZURE:

V. COGNITIVE BEHAVIOUR

CONDITION TYPE/EXPLAIN:

IS THERE A POSSIBILITY YOUR PATIENT'S CONDITION WILL DETERIORATE DURING THE FLIGHT YES ☐ NO ☐

IF YES, PLEASE EXPLAIN:

IS YOUR PATIENT ALERT AND ORIENTED X3 TO PERSON, PLACE AND TIME YES ☐ NO ☐

_____

PHYSICIAN INITIAL

VI. MOBILITY

DO NOT USE THIS FORM TO REQUEST WHEELCHAIR ASSISTANCE. IF YOUR PATIENT EXCEEDS 200KG (440 LBS) AND REQUIRES A TRANSFER, THEN WE ARE UNABLE TO ACCEPT THEM FOR TRAVEL.

WILL YOUR PATIENT REQUIRE A WHEELCHAIR FOR:	DISTANCE	☐
	UNABLE TO ASCEND/DESEND STAIRS	☐
	AT ALL TIMES	☐

CAN YOUR PATIENT SELF-TRANSFER FROM A WHEELCHAIR TO THE AIRCRAFT SEAT	YES ☐	NO ☐
CAN YOUR PATIENT STAND, PIVOT, AND BEAR WEIGHT	YES ☐	NO ☐

VII. SEATING ACCOMMODATIONS

PLEASE INDICATE A SEATING ACCOMMONDATION REQUEST WITH THE MEDICAL RATIONALE TO SUPPORT:

_____
PHYSICIAN INITIAL

VIII. ASSISTANCE REQUIREMENTS

ONCE ON BOARD THE AIRCRAFT IS YOUR PATIENT CAPABLE OF:

TAKING MEDICATION UNAIDED	YES ☐	NO ☐
USING THE TOILET UNAIDED	YES ☐	NO ☐
MANAGING THEIR MEALS UNAIDED	YES ☐	NO ☐

IF NO TO ANY, WHAT ASSISTANCE IS REQUIRED

- FEEDING ☐
- OPENING CONTAINERS ☐
- SET-UP/ORIENTATION ☐

INDICATE ADDITIONAL OR SPECIFIC ASSISTANCE NEEDS YOUR PATIENT REQUIRES ON BOARD THE AIRCRAFT:

OUTLINE OBJECTIVE MEDICAL RATIONALE INCLUDING YOUR PATIENT'S MEDICAL LIMITATIONS AND RESTRICTIONS THAT PREVENTS THEM FROM TRAVELLING INDEPENDENTLY ONCE ON BOARD THE AIRCRAFT:

PLEASE NOTE THAT IF YOUR PATIENT REQUIRES AN ATTENDANT TO TRAVEL WITH THEM, THE ATTENDANT IS REQUIRED TO BE ABLE-BODIED AND ABOVE THE AGE OF EIGHTEEN (18).

_____

PHYSICIAN INITIAL

IX. ADDITIONAL MEDICAL INFORMATION

PLEASE PROVIDE THE ADDITIONAL MEDICAL INFORMATION YOU FEEL IS RELEVANT TO YOUR PATIENT'S SITUATION OR ACCOMMODATION REQUEST:

X. SEATING ACCOMMODATIONS FOR OBESITY

HEIGHT: _____ cm

WEIGHT: _____ kg

WAIST AROUND UMBILICUS: _____ cm

MAXIMUM GIRTH AROUND HIP ABOVE GLUTEAL FOLD: _____ cm

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PHYSICIAN SIGNATURE: _____ DATE: _____