

# FITNESS FOR AIR TRAVEL

### MEDICAL DEPARTMENT

MONDAY TO FRIDAY: SATURDAY TO SUNDAY: EMAIL:

6 a.m. – 10 p.m. ET 6 a.m. – 8 p.m. ET acmedical@aircanada.ca

TEL: 1-800-667-4732 (Toll-free from North America) FAX: 1-888-334-7717 (Toll-free from North America) 1-514-369-7039 (Long distance charges apply) 1-514-828-0027 (Long distance charges apply)

The personal and medical details you provide on this form will be used by Air Canada to handle your request for medical approval and to arrange the necessary assistance for your travel arrangements on Air Canada operated flight(s). Your medical details **will not be disclosed** to other airlines.

In compliance with Accessible Transportation for Persons with Disabilities Regulations, Air Canada can retain an electronic copy of your personal health information for at least three (3) years for the purpose of permitting Air Canada to use that information if you make another request for a service.

Do you agree? Yes No clear

**If yes**, please note Air Canada may require updated documents depending on your medical condition. You should read Air Canada's privacy policy for further information and for the contact details of the privacy office.

I hereby consent to my personal and/or medical data being processed, used for the purposes set out above.

PASSENGER/LEGAL GUARDIAN SIGNATURE	PLACE	DATE

There are 5 sections to this form. Please ensure that the sections relevant to your request are properly filled out by your healthcare provider.

#### The sections are:

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PASSENGER INFORMATION					
FIRST NAME	FAMILY NAME		DATE OF BIF	RTH	
BOOKING REFERENCE		TELEPHONE			
EMAIL					
FLIGHT NUMBER	DATE	FROM		то	
FLIGHT NUMBER	DATE	FROM		то	
FLIGHT NUMBER	DATE	FROM		то	
	•			•	

Please note: The following sections need to be filled out by your healthcare provider who is a physician, nurse practitioner or physician assistant. You can either save and send the form electronically or print it to be filled out by hand. Duly completed forms must be emailed to <a href="mailto:acmedical@aircanada.ca">acmedical@aircanada.ca</a>

An Air Canada health professional or a health professional service provider to Air Canada may call your healthcare provider if the information is incomplete or doesn't provide a sufficient assessment of your condition.

HEALTHCARE PROVIDER INFORMATION				
NAME AND PROFESSIONAL DESIGNATION		LICENCE NU	JMBER	
COUNTRY OR PROVINCE OF REGISTRATION	TELEPHONE		FAX	
EMAIL				

LIEAL THOADE DROVIDED GIONATURE	DATE
HEALTHCARE PROVIDER SIGNATURE	DATE

PASSENGER NAME	BOOKING REFERENCE
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# **PATIENT'S MEDICAL INFORMATION** (MANDATORY FOR ALL FLIGHTS NOT SUBJECT TO SECTION 4 / USA FLIGHTS) **DIAGNOSIS** DATE OF ONSET Is the condition resolved/stable? Yes No Current symptoms and severity: Nature and date of any treatment/surgery: Date:

### ADDITIONAL MEDICAL INFORMATION - ALL QUESTIONS MUST BE ANSWERED

Anemia:	No	Yes – if yes, indicate hemoglobin: g/dL
Requires supplemental oxygen for travel:	No	Yes – if yes, please complete Section 1
Requires attendant or assistance with mobility:	No	Yes – if yes, please complete Section 2a
Respiratory condition (acute or chronic):	No	Yes – if yes, please complete Section 2b
Seizure disorder:	No	Yes – if yes, please complete Section 2c
Cardiac condition (including syncope):	No	Yes – if yes, please complete Section 2d
Psychiatric/Behavioural/Cognitive Condition:	No	Yes – if yes, please complete Section 2e
Allergy to cats or dogs:	No	Yes – if yes, please complete Section 2f

Vital signs:	OXYGEN SATURATION %	ROOM AIR or O <sub>2</sub> L.p.m	BLOOD PRESSURE	HEART RATE
Prognosis for a safe trip:	Good (No problems Anticipated)	Guarded (Potential problems)	Poor (Problems likely)	

HEALTHCARE PROVIDER SIGNATURE	DATE

PASSENGER NAME

xygen saturation	ո: %	Room air					
		O <sub>2</sub>	L.p.m	ı. continu	ous		
		Personal Ox	kygen Con	centrator	(P.O.C.)	pulse settings	s:
		1 2	3 4	5 6			
		P.O.C. cont	tinuou <b>s</b> se	ettings:	1 L.p.m	. 2 L.p.m.	3 L.p.m.
oes the patient a	already use oxygen on	the ground?	Yes	No			
<b>yes</b> , please pro	vide the following infor	mation:					
-	ow rate: L.	. <b>p.m.</b> Hour	s per day				
P.O.C. Bi	rand:						
or	Pulse delivery at sett  Continuous flow deli	•	_	4 5 2 L.p.m.	6 3 L.p.		rs per day  rs per day
	OF THE FOLLOWING						
CHOOSE ONE	OF THE FOLLOWING  Oxygen Request* (p	provided by Air	r Canada - <b>2 L.</b> ړ	– fees ap	plicable / l 3 L.p.m. required	Nasal prongs <b>4 L.p.m.</b>	only, no masl <b>5 L.p.m.</b>
	Oxygen Request∗ (p	provided by Air	r Canada - <b>2 L.</b> ړ	– fees ap	3 L.p.m.		
	Oxygen Request* (p	provided by Air equired flow: required?	r Canada - 2 <b>L.</b> ړ mor	e than 5	3 L.p.m.		
OPTION 1	Oxygen Request* (p Oxygen cylinder – re	provided by Air equired flow: required? provided)	r Canada - 2 L. <sub>I</sub> mor Yes	e than 5	3 L.p.m.		
OPTION 1	Oxygen Request* (p Oxygen cylinder – re  Is a pediatric mask r P.O.C.** (passenger  Pulse delivery a	provided by Air equired flow: required? provided) at setting:	r Canada - 2 L. <sub>I</sub> mor Yes Brand:	- fees ap  o.m. ; e than 5  No  2 3	3 L.p.m. required	4 L.p.m.	
OPTION 1  OPTION 2  or  Is the passenger	Oxygen Request* (possenger  Is a pediatric mask r  P.O.C.** (passenger  Pulse delivery a	provided by Air equired flow: required? provided) at setting: w delivery at:	r Canada - 2 L.; more Yes Brand: 1 1 L.;	- fees ap  o.m.	3 L.p.m. required  4 5 L.p.m.	4 L.p.m. 6 3 L.p.m.	

## ADVANCE NOTICE REQUIRED

(Best efforts will be made to accommodate requests made within this timeframe).

North America: 48 hours 72 hours International: P.O.C. or C.P.A.P.: 48 hours

HEALTHCARE PROVIDER SIGNATURE	DATE



PASSENGER NAME	BOOKING REFERENCE
FASSENGER NAME	BOOKING REFERENCE

SECTION 2 - DECLARATION OF ILLNESS, ACCIDENT OR TREATMENT DATE OF ONSET **DIAGNOSIS** Treatment: Medications: Will a cabin pressure the equivalent to an elevation of 2,400 m (8,000 ft) above sea level (i.e., Yes No a 25% reduction in the ambient partial pressure of oxygen and an expansion of the volume of gas) affect the passenger's medical condition? Does the patient require an attendant to travel? Yes No Medical reason passenger is unable to travel alone: Is an attendant required in flight to assist with eating, medications and toileting? Yes No Who should accompany passenger? Doctor Nurse Other (adult family/friend able to attend to all personal and safety needs) Yes **Bowel Control:** No If no, mode of control: Bladder Control: Yes No If no, mode of control: Able to walk without assistance? Yes No If no, please provide the following information: Wheelchair required for boarding To aircraft To seat Passenger has own wheelchair Electrical Manual For adults with cognitive disabilities not needing an attendant, is airport Yes No assistance required?

HEALTHCARE PROVIDER SIGNATURE

DATE





PASSENGER NAME

# **SECTION 2** – DECLARATION OF ILLNESS, ACCIDENT OR TREATMENT- CONTINUED

b)	Chronic Pulmonary Cond If yes, please provide the		is:	Yes	No							
	Short of breath: Y	es N	o									
	If yes, please provide the	following	g infor	mation	1:	On ex	ertion	Α	t rest			
	Can the passenger tolerate climb 10-12 stairs-without			n-exam	nple, v	valk 10	0 metres	s at a ı	normal pace	or	Yes	No
	Has the passenger recentl	ly taken	a con	nmercia	al airc	raft in t	hese saı	me co	nditions?		Yes	No
	If yes, any medical proble	ms or co	omplic	cations?	?							
	Has the passenger had re-		erial g	ases?		Yes	No					
	If yes, what were the resu pCO <sub>2</sub> pO <sub>2</sub>	ils?		Satur	ation		%	D	ate of exam:			
	Blood gases were taken o	n:	R	oom ai	r	Oxyge	en	L.p	o.m.			
c)	Seizure? Yes N	No										
	Cause/Type:											
	When was the last seizure	?				Last h	ospital v	visit fo	seizure:			
	Are the seizures controlled	d by med	dicatio	on?	Ye	s N	o					
d)	Cardiac conditions?	Yes	No									
	Can the passenger tolerate mild exertion—example, walk 100 metres at a normal pace or climb 10-12 stairs—without symptoms?									e or	Yes	No
	Angina:	Yes	No	Date	of last	episod	le:					
	Limit to physical activity:											
				No	ne		Slight		Marked		Severe	
	Myocardial infarction:	Yes	No	Date:								
				Comp	olicatio	ons:	Yes	s N	0			
				Speci	fy:							
				Low r	isk on	angio	graphy o	r non-	invasive stud	dies?	Yes	No
				If ang	ioplas	sty or co	oronary l	bypas	s, date:			
HEAL	_THCARE PROVIDER SIGNAT	TURE						DA	ΤE			







# **SECTION 2** – DECLARATION OF ILLNESS, ACCIDENT OR TREATMENT- CONTINUED

Car	diac Failure:									
					Functiona	al class:	No sympt	oms		
					Short of b	oreath:	With majo	or effort		
							With light	effort		
							At rest			
Syn	icope:	,	Yes	No	Diagnosis/Pre	esumed cau	ıse:			
					Investigations	s, if any:				
	<b>/chiatric/Beh</b> gnosis:	avioural/Co	ognitiv	ve Co	ondition?	Yes N	lo			
	•	-		-	will become ag	gitated durin	ng the flight, c	ausing safety	Yes	No
risk	or significant	distress to	others	?						
	· ·				ercial aircraft in	this conditi	ion?		Yes	No
Has	· ·	iously flown			Alone				Yes	No
Has	s he/she previ	iously flown			Alone	this conditi			Yes	No
Has	s he/she previ es, did he/she	iously flown			Alone				Yes	No
Has If ye	s he/she previ es, did he/she	iously flown e travel: 'es No	in a co	omme	Alone Accompar		of travel:		Yes	No
Has If ye	s he/she previ es, did he/she ergy? Y	iously flown e travel: <b>′es No</b> ger carry ar	in a co	omme	Alone Accompar	nied - Date o	of travel:		Yes	No
Has If ye	s he/she previes, did he/she ergy? Yes the passen	iously flown to travel:  Yes  Yes	in a co n asthr <b>No</b>	omme	Alone Accompar	nied - Date o	of travel:		Yes	No
Alle Doe	es, did he/she ergy? Y es the passen ergy to cats:	iously flown to travel:  Yes  Yes	in a co n asthr <b>No</b> suffer f	omme ma inh rom:	Alone Accompar	nied - Date o	of travel:	hy skin/rash	<b>Yes</b>	
Alle Doe Alle If ye	es, did he/she ergy?  Y es the passen ergy to cats: es, does the p	iously flown to travel:  Yes  Yes  Dassenger s	in a co n asthr <b>No</b> suffer f	omme ma inh rom:	Alone Accompar naler/pump?	nied - Date o	of travel:	hy skin/rash		
Alle Doe Alle If ye	es, did he/she ergy?  Y es the passen ergy to cats: es, does the p tchy eyes	iously flown e travel:  Yes No ger carry ar Yes passenger s wheezir Yes	in a constant as the suffer front of the suffe	omme ma inh rom:	Alone Accompar naler/pump?	nied - Date o	of travel:	hy skin/rash		
Alle Doe Alle If ye	es, did he/she ergy?  Yes the passen ergy to cats: es, does the p tchy eyes ergy to dogs:	iously flown e travel:  Yes No ger carry ar Yes passenger s wheezir Yes	in a constant asthromother from the constant asthromother from the constant as	omme ma inh rom:	Alone Accompar naler/pump?	nied - Date o	of travel:	hy skin/rash hy skin/rash		nea
Alle Doe Alle If ye  Alle If ye  in	es, did he/she ergy? Y es the passen ergy to cats: es, does the p tchy eyes ergy to dogs: es, does the p	iously flown e travel:  Yes No ger carry ar Yes bassenger s wheezir Yes bassenger s wheezir wheezir	in a contact in a sether forming  No  Suffer forming  No  Suffer forming	omme ma inh rom:	Alone Accompan	Yes No	of travel:		dyspr	nea
Alle Doe Alle If ye  Alle If ye  in	es, did he/she ergy?  Yes the passen ergy to cats: es, does the p tchy eyes ergy to dogs: es, does the p	iously flown e travel:  Yes No ger carry ar Yes bassenger s wheezir Yes bassenger s wheezir wheezir	in a contact in a sether forming  No  Suffer forming  No  Suffer forming	omme ma inh rom:	Alone Accompan	Yes No	of travel:		dyspr	nea

HEALTHCARE PROVIDER SIGNATURE

DATE



### **SECTION 3 – EXTRA SEATING BY REASON OF OBESITY**

### FOR ITINERARIES WHOLLY WITHIN CANADA ONLY

THIS SECTION REQUIRED ONLY IF REQUESTING AN EXTRA SEAT FOR REASONS OF OBESITY

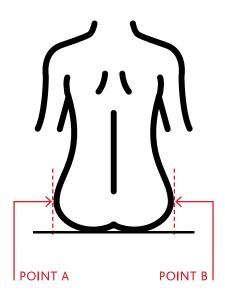
The information provided herein will assist Air Canada in determining passenger's right to accommodation in the form of extra seating without charge.

For first assessment, please ensure all sections above are completed by the attending physician.

If this is a renewal, this section can be completed by an occupational therapist, a physiotherapist or nurse practitioner provided no other co-morbidities had been identified by the physician in the initial assessment and passenger's fitness for flying has not changed in the last 2 years.

## **Measurements** (please use metric measurements)

- a) Weight \_\_\_\_ kg
- b) Height cm
- c) Body Mass Index (kg/m<sub>2</sub>)
- d) Surface measurement\* A to B cm
  - \*Surface measurement should be calculated by measuring the distance between the extreme widest projection points of the patient when seated as per the following instructions:
  - 1. Have your patient sit on a paper covered examination table.
  - 2. Rest a ruler or straightedge on the left side of patient at the widest point (hip or waist) as shown on diagram at right.
  - 3. Mark the touch point between the ruler and the paper as Point A.
  - 4. Rest a ruler or straightedge on the right side of patient at the widest point (hip or waist).
  - 5. Mark the touch point between the ruler and the paper as Point B.
  - 6. Measure the distance between Point A and Point B, and indicate this measurement above under "Surface Measurement" (item d).



Call the Air Canada Medical Assistance Desk at 1-800-667-4732 and provide your booking reference in order to request extra seating for medical reasons and make any other necessary arrangements for your flight.







**SECTION 4 – TRAVELLING BETWEEN CANADA AND THE U.S.A.** 

FOR PASSENGERS TRAVELLING ON A FLIGHT BETWEEN CANADA AND THE U.S.A., **WE ONLY REQUIRE THE COMPLETION OF THIS SECTION 4** OF *THIS FITNESS FOR AIR TRAVEL* FORM.

WE STRONGLY RECOMMEND THAT SECTION 2 BE COMPLETED BY THE ATTENDING PHYSICIAN TO ENSURE THAT PASSENGER'S CONDITION WILL NOT BE AGGRAVATED IN A HYPOXIC CABIN ENVIRONMENT.

#### 1) Reasonable doubt

Will the passenger be able to complete the flight safely without requiring extraordinary medical attention?

Yes No

If no, the passenger:

- a) Has an unstable medical condition;
- b) Has a medical condition that may worsen in a hypoxic environment;
- c) May require medical assistance during flight;
- d) May require the use of onboard emergency medical equipment; or
- e) Is unable to self-administer medications or routine medical care necessary to maintain the stability of his/her condition during a flight (e.g., insulin injection).

### 2) Communicable diseases

a) Does the passenger have a disease or infection that would under the present conditions be communicable to other persons and that could pose a direct threat to the health or safety of others during the normal course of the flight?

Yes No

b) Are there any conditions or precautions that would have to be observed to prevent the transmission of the disease or infection to other persons in the normal course of the flight?

Yes No

If yes, state which:

c) Does the passenger have a bonafide medical condition which would preclude them from wearing a facial covering or mask?

Yes No

### 3) Oxygen

Does the passenger use oxygen on the ground or will the passenger require supplemental oxygen in flight?

Yes No

If yes, please complete SECTION 1 (page 3)

**CLEAR FORM** 

HEALTHCARE PROVIDER SIGNATURE

DATE\*

<sup>\*</sup>Must be dated within 10 days of the date of the initial departing flight.