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)
1-514-369-7039 (Long distance charges apply)

FAX: **1-888-334-7717** (Toll-free from North America)
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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AIR CANADA
A STAR ALLIANCE MEMBER

PASSENGER INFORMATION

FIRST NAME	FAMILY NAME	DATE OF BIRTH

BOOKING REFERENCE	TELEPHONE

EMAIL

FLIGHT NUMBER	DATE	FROM	TO
FLIGHT NUMBER	DATE	FROM	TO
FLIGHT NUMBER	DATE	FROM	TO

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 acmedical@aircanada.ca

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 NUMBER

COUNTRY OR PROVINCE OF REGISTRATION	TELEPHONE	FAX

EMAIL

HEALTHCARE PROVIDER SIGNATURE	DATE

PASSENGER NAME

BOOKING REFERENCE

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
Requires exemption from wearing face covering:	☐ No	☐ Yes – if yes, please complete Section 2b + e

Vital signs:	OXYGEN SATURATION %	☐ ROOM AIR or ☐ O_2 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 _____ BOOKING REFERENCE _____

SECTION 1 – TRAVELLING WITH OXYGEN

Oxygen saturation: _____ %

☐ Room air

☐ O_2 _____ **L.p.m.** continuous

☐ Personal Oxygen Concentrator (P.O.C.) **pulse** settings:

☐**1** ☐**2** ☐**3** ☐**4** ☐**5** ☐**6**

☐ P.O.C. **continuous** settings: ☐**1 L.p.m.** ☐**2 L.p.m.** ☐**3 L.p.m.**

Does the patient already use oxygen on the ground? ☐ **Yes** ☐ **No**

If yes, please provide the following information:

☐ O_2 tank Flow rate: _____ **L.p.m.** Hours per day _____

☐ P.O.C. Brand: _____

☐ **Pulse** delivery at settings: ☐**1** ☐**2** ☐**3** ☐**4** ☐**5** ☐**6** Hours per day _____

or ☐ **Continuous** flow delivery at: ☐**1 L.p.m.** ☐**2 L.p.m.** ☐**3 L.p.m.** Hours per day _____

CHOOSE ONE OF THE FOLLOWING OPTIONS FOR FLIGHT

☐ **OPTION 1** **Oxygen Request*** (provided by Air Canada – fees applicable / Nasal prongs only, no mask)

Oxygen cylinder – required flow: ☐**2 L.p.m.** ☐**3 L.p.m.** ☐**4 L.p.m.** ☐**5 L.p.m.** ☐**more than 5 required**

Is a pediatric mask required? ☐**Yes** ☐**No**

☐ **OPTION 2** **P.O.C.**** (passenger provided) Brand: _____

☐ **Pulse** delivery at setting: ☐**1** ☐**2** ☐**3** ☐**4** ☐**5** ☐**6**

or ☐ **Continuous** flow delivery at: ☐**1 L.p.m.** ☐**2 L.p.m.** ☐**3 L.p.m.**

Is the passenger familiar with their P.O.C. and capable of managing the device on their own, including responding to alerts and changing of batteries? ☐ **Yes** ☐ **No**

Does the passenger have sufficient batteries for their trip? (Aircraft do not have electrical outlets able to support power to a P.O.C.) ☐ **Yes** ☐ **No**

ADVANCE NOTICE REQUIRED

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

* North America: 48 hours

International: 72 hours

** P.O.C. or C.P.A.P.: 48 hours

HEALTHCARE PROVIDER SIGNATURE _____ DATE _____

PASSENGER NAME

BOOKING REFERENCE

SECTION 2 – DECLARATION OF ILLNESS, ACCIDENT OR TREATMENT

DIAGNOSIS	DATE OF ONSET

Treatment: _____

Medications: _____

Will a cabin pressure the equivalent to an elevation of 2,400 m (8,000 ft) above sea level (i.e., a 25% reduction in the ambient partial pressure of oxygen and an expansion of the volume of gas) affect the passenger's medical condition? ☐ **Yes** ☐ **No**

a) 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)

Bowel Control: ☐ **Yes** ☐ **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 assistance required? ☐ **Yes** ☐ **No**

HEALTHCARE PROVIDER SIGNATURE

DATE

PASSENGER NAME _____ BOOKING REFERENCE _____

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

b) Chronic Pulmonary Condition ☐ **Yes** ☐ **No**

If yes, please provide the diagnosis: _____

_____

_____

Short of breath: ☐ **Yes** ☐ **No**

If yes, please provide the following information: ☐ On exertion ☐ At rest

Can the passenger tolerate mild exertion-example, walk 100 metres at a normal pace or climb 10-12 stairs-without symptoms? ☐ **Yes** ☐ **No**

Has the passenger recently taken a commercial aircraft in these same conditions? ☐ **Yes** ☐ **No**

If yes, any medical problems or complications?

_____

Has the passenger had recent arterial gases? ☐ **Yes** ☐ **No**

If yes, what were the results?

pCO_2 _____ pO_2 _____ Saturation _____ % Date of exam: _____

Blood gases were taken on: ☐ Room air ☐ Oxygen _____ **L.p.m.**

c) Seizure? ☐ **Yes** ☐ **No**

Cause/Type: _____

When was the last seizure? _____ Last hospital visit for seizure: _____

Are the seizures controlled by medication? ☐ **Yes** ☐ **No**

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? ☐ **Yes** ☐ **No**

Angina: ☐ **Yes** ☐ **No** Date of last episode: _____

Limit to physical activity:

☐ None ☐ Slight ☐ Marked ☐ Severe

Myocardial infarction: ☐ **Yes** ☐ **No** Date: _____

Complications: ☐ Yes ☐ No

Specify: _____

Low risk on angiography or non-invasive studies? ☐ Yes ☐ No

If angioplasty or coronary bypass, date: _____

HEALTHCARE PROVIDER SIGNATURE _____ DATE _____

PASSENGER NAME _____ BOOKING REFERENCE _____

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

d) **Cardiac Failure:** ☐ **Yes** ☐ **No** Date of last episode: _____

☐ **Functional class:** ☐ No symptoms

☐ **Short of breath:** ☐ With major effort

☐ With light effort

☐ At rest

Syncope: ☐ **Yes** ☐ **No** Diagnosis/Presumed cause: _____

Investigations, if any:

_____

_____

e) **Psychiatric/Behavioural/Cognitive Condition?** ☐ **Yes** ☐ **No**

Diagnosis:

_____

Is there a possibility that the passenger will become agitated during the flight, causing safety risk or significant distress to others? ☐ **Yes** ☐ **No**

Has he/she previously flown in a commercial aircraft in this condition? ☐ **Yes** ☐ **No**

If yes, did he/she travel: ☐ Alone

☐ Accompanied - Date of travel: _____

f) **Allergy?** ☐ **Yes** ☐ **No**

Does the passenger carry an asthma inhaler/pump? ☐ **Yes** ☐ **No**

Allergy to **cats:** ☐ **Yes** ☐ **No**

If yes, does the passenger suffer from:

☐ itchy eyes ☐ wheezing ☐ runny nose ☐ cough ☐ itchy skin/rash ☐ dyspnea

Allergy to **dogs:** ☐ **Yes** ☐ **No**

If yes, does the passenger suffer from:

☐ itchy eyes ☐ wheezing ☐ runny nose ☐ cough ☐ itchy skin/rash ☐ dyspnea

Other medical information:

_____

_____

_____

HEALTHCARE PROVIDER SIGNATURE _____ DATE _____

PASSENGER NAME

BOOKING REFERENCE

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

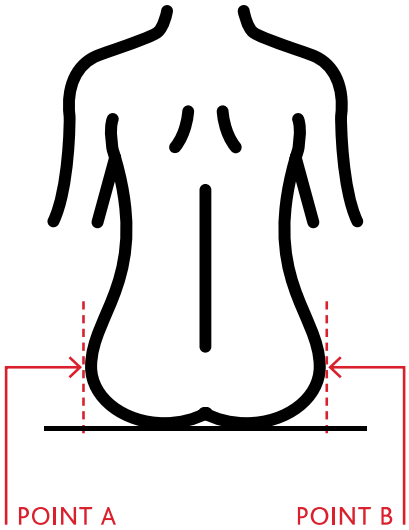
b) Height _____ cm

c) Body Mass Index _____ (kg/m^2)

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.

HEALTHCARE PROVIDER SIGNATURE

DATE

PASSENGER NAME _____ BOOKING REFERENCE _____

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

*Must be dated within 10 days of the date of the initial departing flight.

HEALTHCARE PROVIDER SIGNATURE _____ DATE* _____