Philippine Airlines

MEDICAL INFORMATION FORM (MEDIF)

PART I: To be accomplished by Sales Office/Agent

PLEASE COMPLETE THE FORM IN BLOCK LETTERS

Airlines' Ref. code MEDA 1	Name of Passenger:	Sex:	Age:	Weight:	Height:
MEDA 2	Address:		Contact No(s):		

PROPOSED ITINERARY	ROUTING	CARRIER	FLT. NO.	CLASS	DATE	BOOKING REF.

MEDA 3 NATURE OF PHYSICAL CONDITION: BLIND ☐ DEAF/MUTE ☐ OTHERS:

PART II: MEDICAL INFORMATION (To be completed by ATTENDING PHYSICIAN prior to submission to PAL Medical for clearance)

Passenger's Declaration: (Where needed, to be read by/to passenger, dated and signed by him/her, or on his/her behalf).
(For Medical Case Only)

"I HEREBY AUTHORIZE _____ to provide the airlines with the information required by the
(Name of Nominated Physician)
airlines' medical department for the purpose of determining my fitness for carriage by air and in consideration thereof I hereby relieve that physician of his/her professional duty of confidentiality in respect of such information, and agree to meet such physician's fee in connection therewith.

I take note that, if accepted for carriage, my journey will be subject to the general conditions for carriage/tariffs of the carrier concerned and the carrier does not assume any special liability exceeding those conditions/tariffs.

I agree to reimburse the carrier upon demand for any special expenditures or costs in connection with my carriage."

Passenger's Signature:	Place:	Date:

Information written in this form shall be **CONFIDENTIAL**.
The PHYSICIAN ATTENDING to the incapacitated passenger is requested to ANSWER ALL QUESTIONS (Enter a cross "X" in the appropriate "yes" or "no" box and/or give precise answers).

IMPORTANT:
(**)Fees, if any, relevant to the provision of the information below, including but not limited to OXYGEN BOTTLES, STRETCHER and/or AMBULANCE are to be paid by the passenger concerned.

NOTE:
(*)Cabin Attendants are NOT authorized to give special assistance to a particular passenger to the detriment of their services to other passengers. Additionally, they are trained only to render FIRST AID and are NOT PERMITTED to administer any injection or to give any medication.

FOR PAL PHYSICIAN'S USE ONLY

DATE:_____

☐ Clearance for air travel **DENIED**

☐ Okay for **BOOKING**; To report to **PAL Medical Clinic** 4 hours before check-in time.

☐ **CLEARED** for air travel until_____

_____
PRINTED NAME & SIGNATURE OF PAL PHYSICIAN

MEDA 4	ATTENDING PHYSICIAN	Name:	
		Contact Nos. Business:	Home:
MEDA 5	MEDICAL DATA Diagnosis in detail: (including vital signs)		Date of Diagnosis: > ILLNESS: _____ > SURGERY: _____ > INJURY : _____

MEDA 6

WHEELCHAIR needed? NO ☐ YES ☐ Collapsible? NO ☐ YES ☐ Wheelchair category : WCHR ☐
Own wheelchair? NO ☐ YES ☐ Battery type, spillable? NO ☐ YES ☐ WCHC ☐
Power driven? NO ☐ YES ☐ WCHS ☐

Wheelchairs with **spillable batteries** are **"dangerous goods"** and are permitted on passenger aircraft only under certain conditions, which can be obtained from the airline(s). In addition, certain countries may impose specific restrictions

MEDA 7	Is STRETCHER needed on board the aircraft? ** NO ☐ YES ☐	If YES, type of escort required:	
MEDA 8	Does patient need OXYGEN on board? ** NO ☐ YES ☐	Liters per minute:	Type of escort required:
		Continuous? YES ☐ NO ☐	No. of OXYGEN tanks reqd:
MEDA 9	PROGNOSIS for the trip: GOOD ☐ FAIR ☐ POOR/GUARDED ☐		
MEDA 10	Contagious/communicable disease? NO ☐ YES ☐	Specify:	
MEDA 11	Is patient's condition likely to be a source of discomfort to other passengers? (Odor, appearance, conduct) NO ☐ YES ☐	Specify:	
MEDA 12	Can patient use normal aircraft seat with seatback placed in UPRIGHT position when required? NO ☐ YES ☐	Remarks:	
MEDA 13	Can patient take care of his own needs on board UNASSISTED (including meals, visit to the toilet, etc.)? NO ☐ YES ☐	If YES, type of help needed:	
MEDA 14	Does patient need any MEDICATION* other than self-administered and/or the use of special apparatus such as respirator, incubator, etc.**?	A) on the GROUND while at the airport(s): NO ☐ YES ☐ Specify:	
MEDA 15	**(Clearance with PAL Safety & Environment Department required)**	B) aboard the AIRCRAFT: NO ☐ YES ☐ Specify:	
MEDA 16	Does patient need HOSPITALIZATION? (If YES, indicate arrangements made or, if NONE were made, indicate "NO ACTION TAKEN")	A) during long layover or nightstop at CONNECTING POINTS en route? NO ☐ YES ☐ Action:	
MEDA 17		B) upon arrival at DESTINATION: NO ☐ YES ☐ Action:	
MEDA 18	Other remarks or information in the interest of your patient's smooth and comfortable transportation? NONE ☐ YES ☐	Specify:	
MEDA 19	Ambulance** requirement: NO ☐ YES ☐	NAME OF AMBULANCE:	PLATE NO.: NAME OF DRIVER:
MEDA 20	Name of companion/paramedic onboard ambulance:		

Attending Physician's Signature:	Place:	Date:

Copy Distribution: 1 - Origin Stn. (WHITE) 2 - Boarding Stn.(BLUE) 3 - Destination Stn. (PINK)c/o Purser 4 - Attending Physician (GREEN) 5 - Passenger (WHITE)