



MEDICAL INFORMATION

Dear passenger:

In order to provide the appropriate attention to your request of Special Services, you are required to ask your physician to fill out this format, which must be sent before the timeframes established, based on the service requested, by e-mail to serviciosespeciales@aeromexico.com so that it is reviewed and assessed by the Aeromexico Medical Service.

General Conditions:

- Aeromexico do not provide any special service before boarding the plane, during connections or upon arrival.
- The passenger must be accompanied by an adult at all times.
- This document will be reviewed and endorsed by the Aeromexico Medical Service, with full powers to authorize or deny the service.
- Any of our services can be offered only on non-stop direct flights, and when they are operated directly by Aeromexico.
- The cost of each of the services is specified in the "Special Services" section.
- The flight crew is not authorized to provide special attention to any passenger, and they are not allowed to administer any medications or injections.
- All the arrangements required to request access to ambulances, physicians, etc., in the airport must be performed directly by the passenger in advance with the corresponding airport authorities.
- Aeromexico provides exclusively the stretcher service and cannot interfere in the access request or authorization.

GENERAL INFORMATION

Full name of the passenger for whom the Special Service is Required:

Indicate the service(s) required by the passenger (Therapeutic oxygen cylinder(s) on board, oxygen concentrator use on board, stretcher or incubator):

Confirmation / reservation number:

Flight number / date:



Telephone numbers of the passenger, including the area or country code:

(____) _____

(____) _____

Full name of the person that accompanies the passenger (must be over 18 years of age):

Telephone numbers of the person that accompanies the passenger, including area or country code:

(____) _____

(____) _____

MEDICAL INFORMATION

This information must be completed only by the treating physician of the passenger.

Full name of the passenger: _____

Age of the passenger: _____ Allergies: _____

Disorder / disease onset date: ____/____/____

Diagnosis, including vital signs:

Travel prognosis:

Treatment (s):

Surgery (ies):

Current health status (catheters, saline solution, state of awareness, walks on his/her own, etc):

Medications taken:

In case the patient requires therapeutic oxygen cylinder(s) on board, please indicate only one of the following options.

1. Flow in LPM		2. Administration route		3. Supply	
2	4	Mask	Nasal cannula	Intermittent	Continuous

In case the patient travels with his/her own Oxygen Concentrator equipment, indicate the brand and model:

In case the patient has to travel in an incubator, please indicate the brand and model:



I, Dr. _____ with Professional License Number _____, under protest to tell the truth, state and certify that this patient is under my care and that is fit to travel by air safely, without requiring any additional medical care during his/her flight, even if the flight duration were longer than expected or if it ended in a different location for operational requirements or for any other issue beyond the control of the airline company, or if any setback occurred during the itinerary. I also certify that the above-mentioned patient does not suffer any infectious or transmissible disease that could be transmitted to other passengers during the flight. I confirm as well that his/her transportation will not represent any trouble for the rest of the passengers.

Full name: _____ Date: _____

Specialty: _____

Address: _____

Telephones: (office, hospital):

Cellular phone, Nextel or pager number:

Signature:
