

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.

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

- 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

Indicate the service(s) required by the passenger (7 oxygen concentrator use on board, stretcher or incu	
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:
Diagnosis, molacing that signs.
Travel prognosis:
Treatment (s):
Surgery (ies):
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Current hea	alth status	(catheters, sa	aline solution, state of aw	areness, walks on h	is/her own, etc):	
Medications	s taken:					
one of the	following o	ptions.	eutic oxygen cylinder(s) o		·	
1. Flow	in LPM	2. Ad	ministration route	3. Su	3. Supply	
2	4	Mask	Nasal cannula	Intermittent	Continuous	
In case the brand and		avels with his/h	ner own Oxygen Concenti	rator equipment, inc	dicate the	
In case the	patient ha	as to travel in a	n incubator, please indic	ate the brand and r	model:	



l, Dr	wit
Professional License Number	, under protest to te
the truth, state and certify that this patient is under medically, without requiring any additional medical care deduration were longer than expected or if it ended in requirements or for any other issue beyond the control of occurred during the itinerary. I also certify that the above-any infectious or transmissible disease that could during the flight. I confirm as well that his/her transportation	ny care and that is fit to travel by a luring his/her flight, even if the flight a different location for operations of the airline company, or if any setbace-mentioned patient does not suffer be transmitted to other passenger
rest of the passengers.	
Full name: I	Date:
Specialty:	
Address:	
Telephones: (office, hospital):	
Cellular phone, Nextel or pager number:	
Signature:	