

**CONSENT FOR FINNAIR TO HANDLE SENSITIVE PERSONAL DATA**

By submitting this form, you give us your consent to process your medical data to handle and complete your service request. The consent also applies to our partners if necessary. Find out more about our Privacy Policy: <https://www.finnair.com/privacy-policy/>

Name	Date and place	Signature
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The Sales office, agent or passenger should complete this form.

Please answer all of the questions, marking an 'x' in the 'Yes' or 'No' boxes and using block letters or typing when completing the form.

1. Passenger's first name	Last name	Date of birth	Gender
2. Proposed itinerary: date(s), flight number(s), from-to			
3. Diagnosis or other reason for special arrangements			
4. Is the passenger able to walk 50 meters or climb 10-12 steps without difficulties? <input type="checkbox"/> Yes <input type="checkbox"/> No, specify _____			
5. Is a wheelchair needed? <input type="checkbox"/> No <input type="checkbox"/> Yes, WCHR (R = Ramp) The passenger is able to go up/ come down steps and can enter and exit the aircraft by himself/herself. <input type="checkbox"/> WCHS (S = Steps) The passenger is not able to go up / come down steps, but can get on the aircraft seat by himself/herself (needs a wheelchair to get from the terminal to the plane, and is carried on and off the plane). <input type="checkbox"/> WCHC (C = Cabin Seat) The passenger is completely incapable of movement, he/she must be carried to the seat on the plane, and off again.	Weight and measurements of the wheelchair _____ <input type="checkbox"/> Passenger's own wheelchair <input type="checkbox"/> Foldable wheelchair <input type="checkbox"/> Motorized wheelchair <input type="checkbox"/> Spillable batteries <input type="checkbox"/> Non-spillable batteries  <b>Permission for transport of a motorized wheelchair must always be obtained from the airline in advance.</b>		
6. Is an ambulance needed? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify name and telephone number of ambulance company and name of hospital at destination)			
7. Are other ground arrangements needed? Note! Finnair does not provide any ground arrangements. <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, specify below contact information of persons and organisations requested to assist Assistance to the aircraft at airport of departure <input type="checkbox"/> No <input type="checkbox"/> Yes, specify _____ Assistance between flights <input type="checkbox"/> No <input type="checkbox"/> Yes, specify _____ Assistance on arrival at destination <input type="checkbox"/> No <input type="checkbox"/> Yes, specify _____ Other assistance or valuable information <input type="checkbox"/> No <input type="checkbox"/> Yes, specify _____			
8. Are any special in-flight arrangements needed, such as extra seat or special equipment? See Note 2 at the bottom of Page 2. <input type="checkbox"/> No <input type="checkbox"/> Yes, specify at MEDA11-MEDA12 on page 2.			
9. Is a stretcher needed onboard? <input type="checkbox"/> No <input type="checkbox"/> Yes. An escort with a medical training is required.			
10. Name, age and qualifications of medically trained escort. If the escort has no medical training, write "Travel companion" and the person's name.			
11. If the passenger is deaf and/or blind, is he or she being escorted by a trained dog? <input type="checkbox"/> No <input type="checkbox"/> Yes			

**This text should be read by or to the passenger, dated and signed by him or her or on his or her behalf.**

I hereby authorise all physicians and hospitals to provide the airlines with the information required by these airlines' medical departments, for the purpose of determining my fitness for carriage by air. I therefore relieve these physicians of their vow of professional secrecy in respect to such information and agree to pay the physicians' fees in this matter.

I am aware that, if accepted for carriage, my journey will be subject to the General Conditions of Carriage and the conditions of tariffs of the carriers concerned, and that the carriers do not assume any special liability exceeding these conditions.

I am prepared, at my own risk, to bear any consequences which carriage by air may have on my state of health, and I release the carriers, their employees, servants and agents from any liability for such consequences.

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

Passenger's or guardian's phone number and e-mail address
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Place and date	Passenger's or guardian's signature
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If your medical condition/travel details change in any way prior to travelling, you are requested to contact Finnair Plc.

**Confidential medical information form for air travel**

 If you have a case reference number, attach the file to your case via this [form](#). If you don't have one, [fill in a new form](#) and attach the file to it.

**For official use only.**

This form should be completed by the attending physician.

Please answer all questions, marking an 'x' in the 'Yes' or 'No' boxes and using block letters or typing when completing the form. Fill in all boxes to avoid further enquiries

This form is intended to provide confidential information to enable the airlines' Medical Clearance Services to assess if the passenger is fit to travel as indicated on Page 1. If the passenger is accepted for travel, this information will permit the issuance of necessary instructions to ensure the passenger's welfare, comfort and safety during the flight. Incomplete forms will be returned and may cause a delay in the process. Please complete the form in capital letters using black ink.					
<b>MEDA01</b>	Patient's full name	Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth	Height (cm) Weight (kg)
<b>MEDA02</b>	Attending physician's name, telephone, fax number and email address (necessary in case further information is required)				
<b>MEDA03</b>	Diagnosis in detail, including vital signs (especially oxidation and Hb), present state briefly				
	Date of first symptoms		Date of diagnosis, length of hospitalisation		
<b>MEDA04</b>	Prognosis for the trip				
<b>MEDA05</b>	Does the patient have a contagious or communicable disease? <input type="checkbox"/> No <input type="checkbox"/> Yes, specify				
<b>MEDA06</b>	Psychiatric conditions <input type="checkbox"/> No <input type="checkbox"/> Yes				
	Is there a possibility that the patient will become agitated during the flight? <input type="checkbox"/> No <input type="checkbox"/> Yes				
	Can the patient's behaviour be disturbing to other passengers? <input type="checkbox"/> No <input type="checkbox"/> Yes, specify				
<b>MEDA07</b>	Can the patient use a normal aircraft seat with the seatback in the upright position when so required? <input type="checkbox"/> Yes <input type="checkbox"/> No, specify				
<b>MEDA08</b>	Can the patient take care of his or her own needs onboard unassisted, including meals, visits to toilets etc? (See Note 1 at the bottom of the page.) <input type="checkbox"/> Yes <input type="checkbox"/> No, specify type of help needed				
	Does patient have normal bladder control? <input type="checkbox"/> Yes <input type="checkbox"/> No. If No, give mode of control				
<b>MEDA09</b>	Does the patient need to be escorted? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	Is the intended escort capable and prepared to provide all assistance including feeding, toileting and lifting as required? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	PNR for escort (if different)				
	Is the arrangement proposed on Page 1 satisfactory, in your opinion? <input type="checkbox"/> Yes <input type="checkbox"/> No, specify type of escort proposed by you				
<b>MEDA10</b>	Chronic pulmonary condition <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, SpO <sub>2</sub> on air and date taken:				
	a) Has the patient had recent arterial blood gases? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	b) Blood gases were taken on		<input type="checkbox"/> Room air <input type="checkbox"/> Oxygen	Liters per minute (LPM)	
	If yes, what were the results?		pCO <sub>2</sub> (kPa/mm Hg) % Saturation	pO <sub>2</sub> (kPa/mm Hg) Date of test	
	c) Does the patient retain CO <sub>2</sub> ? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	Has a Hypoxic Challenge Test been undertaken?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Date of test	Results
	d) Has his/her condition deteriorated recently? <input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>MEDA11 - a)</b>	Does the patient need any medication or does the patient need to use any special apparatus such as a respirator (See Note 1 and 2)?				
<b>MEDA12 - b)</b>	a) On the ground <input type="checkbox"/> No <input type="checkbox"/> Yes, specify		b) Onboard the aircraft <input type="checkbox"/> No <input type="checkbox"/> Yes, specify		
Specify medication or apparatus (manufacturer, model and brand, battery or supply current, is apparatus needed also during takeoff and landing?)					
<b>MEDA13 - a)</b>	Does the patient need hospitalisation?				
<b>MEDA14 - b)</b>	a) During a long layover <input type="checkbox"/> No <input type="checkbox"/> Yes		b) Upon arrival at destination <input type="checkbox"/> No <input type="checkbox"/> Yes		
Specify arrangements made					
<b>MEDA15</b>	Other remarks or information in the interests of your patient's smooth, comfortable and safe transportation <input type="checkbox"/> No <input type="checkbox"/> Yes, specify				
<b>MEDA16</b>	Other arrangements made by the attending physician				
<b>Note 1</b> Cabin attendants are not authorized to give special assistance to particular passengers to the detriment of service to other passengers. Cabin attendants are trained only in first aid and are not permitted to administer any injection or to give medication. Cabin crew are employed as food handlers and are therefore unable to assist with toileting needs.					
<b>Note 2</b> Any possible fees which are relevant to the provision of the above information and for carrier-provided special equipment shall be paid by the patient.					
Place and date			Attending physician's signature		