

## Solomon Airlines Medical Travel Clearance Form - Part A

**Prior to travel**

1. This form is to be used by passengers whom have a medical condition and intend to travel on a flight operated by Solomon Airlines including its subsidiaries.
2. This form is to be completed by the treating medical practitioner ensuring the Travel Clearance Guidelines are referred to assist in making a determination if a passenger is fit to travel by air.
3. If the Travel Clearance Guidelines indicate further information is required, a corresponding Part B form must also be completed by the treating medical practitioner.
4. A copy of the Travel Clearance form must be returned to Solomon Airlines at your earliest convenience prior to the proposed date of travel. All sections must be completed.
5. Please return both Part A and Part B (where required) to: E: [reservations@flysolomons.com](mailto:reservations@flysolomons.com)
6. If you as the medical practitioner believe that special consideration should apply to an individual patient, please contact our reservations team and they will provide the details for our medical team.

1. PASSENGER DETAILS (to completed by the passenger)				
NAME:			AGE	
			:	
PHONE NUMBER:				
2. TRAVEL INFORMATION (to be completed by the passenger)				
Booking ref #:				
Flight Sector	Date of flight	Flight Number	Travelling from	Travelling to
1				
2				
3				
4				
3. MEDICAL INFORMATION (to be completed by the treating Doctor)				
<i>* Non completion of this section will result in this form being returned, which may cause a delay in travel</i>				
<b>Medical Condition:</b>				
<b>Date of Diagnosis:</b>				
<small>(including onset of current illness, episode, accident and treatment)</small>				
<b>Date of Surgery:</b>				
4. OXYGEN REQUIREMENTS (to be completed by the treating Doctor)				
(a) Is supplemental oxygen required in flight? <input type="checkbox"/> NO <input type="checkbox"/> YES				
(b) If YES Flow rate                      2L/ min                      Intermittent / Continuous				
4L/min                                      Intermittent / Continuous				
Passenger to provide their own oxygen with the tank not exceeding 5kg in weight.				

**5. ASSISTANCE REQUIREMENTS (to be completed by the treating Doctor)**

- (a) Is a wheelchair required to the aircraft door/ seat  NO  YES  DOOR  SEAT
- (b) Can the passengers walk up and down stairs  NO  YES
- (c) Is an escort required inflight to assist with eating, medications and toileting?  NO  YES
- (d) Is a medically trained escort necessary?  NO  YES

If YES, name and medical qualifications must be completed:

Name of Escort \_\_\_\_\_

Qualifications of Escort \_\_\_\_\_

Booking Reference \_\_\_\_\_

- (e) Is any of the following equipment required?  NO

YES If YES please specify:  Stretcher\*

Humidicrib \*

Other medical equipment\*\* \_\_\_\_\_

*(\*An ambulance is required for all stretcher and Humidicrib cases, clearance cannot be provided until ambulance bookings are confirmed) (\*\* All electrical medical equipment must be approved)*

**Additional clinical information may be required: (please indicate if YES and complete Part B)**

- |                           |                             |   |
|---------------------------|-----------------------------|---|
| <b>1. Cardiopulmonary</b> | <input type="checkbox"/> NO | <input type="checkbox"/> YES (if YES complete PART B) |
| <b>2. Cancers</b>         | <input type="checkbox"/> NO | <input type="checkbox"/> YES (if YES complete PART B) |
| <b>3. Neurological</b>    | <input type="checkbox"/> NO | <input type="checkbox"/> YES (if YES complete PART B) |
| <b>4. Psychiatric</b>     | <input type="checkbox"/> NO | <input type="checkbox"/> YES (if YES complete PART B) |

**6. DOCTORS DECLARATION (to be completed by the treating Doctor)**

*I have read and understood the Solomon Airlines travel Clearance Guidelines and I certify that the above-named passenger has been assessed by me as fit to travel on the nominated flights. I further certify that this person does not have any contagious disease that could directly place another passenger or the crew at risk, or that would contravene relevant Quarantine or Public Health Departments regulations.*

I, (name of doctor) \_\_\_\_\_ hereby declare that to

the best of my knowledge, (name of passenger) \_\_\_\_\_ is fit to travel.

*(As a courtesy, Solomon Airlines may notify any doctor who clears a passenger for travel if the condition of the passenger deteriorates inflight, or if the level of care required for that passenger results in an interruption to normal operations.)*

\_\_\_\_\_  
Doctor's signature and qualifications

\_\_\_\_\_  
Date

\_\_\_\_\_  
Practice contact number (business hrs)

\_\_\_\_\_  
After hours contact number

**7. PASSENGERS DECLARATION (to be completed by the passenger)**

*I declare that the information contained on this Part A and Part B (where applicable) is complete and accurate. I authorize Solomon Airlines to use and release this information as required in the event of an emergency. I acknowledge that airline staff are not medically trained and that the airline cannot guarantee that I will receive appropriate medical attention in any situation. I acknowledge that Solomon Airlines reserves the right to refuse travel, notwithstanding completion of this form, if the airline considers that it is not in my best interest to fly.*

\_\_\_\_\_  
Passenger signature

\_\_\_\_\_  
Date

*Solomon Airlines Privacy Collection Notice*

*Solomon Airlines collects information about you (including health information where necessary) to provide products and services to you, facilitate your participation in our and other organisations' loyalty programs, ensure the safety and security of all passengers when travelling with us, conduct marketing activities for our and third parties' products and services and conduct market research.*

*We may collect your personal information from people who make or update your travel booking or otherwise interact with us on your behalf, from our related bodies corporate entities, from our service providers and from immigration, customs, border security and other regulatory authorities.*

*For the reasons described above, we may disclose your personal information to:*

- our related companies, other carriers and organisations which provide services to us (such as ground handling and other travel related services, call centre operation, market research and marketing services, and services associated with complaints or security incident investigation);*
- your employer if you are travelling for work purposes on a ticket purchased by your employer\*;* and
- others to comply with our legal obligations, including to various law enforcement agencies, regulatory authorities and governments for security, customs and immigration purposes.*

*These parties may be located overseas including in the United Kingdom, the United States, Germany and any country which you travel to or through with us or our partner airlines.*

*\*The information disclosed to your employer may include your travel details and any information associated with your travel (such as incident reports).*

## Solomon Airlines Group Medical Travel Clearance Form - Part B

<b>1. CARDIOPULMONARY</b>	
<ul style="list-style-type: none"> <li><input type="checkbox"/> Is the condition stable? YES <input type="checkbox"/> NO <input type="checkbox"/> _____</li> <li><input type="checkbox"/> When was the last episode or event? Date: _____ SaO2 (room air) _____%</li> <li>• Exercise tolerance (can the patient walk at a moderate pace 50m or climb 10-12 stairs without symptoms?) YES <input type="checkbox"/> NO <input type="checkbox"/></li> <li>• Stress ECG undertaken? YES <input type="checkbox"/> Results _____ NO <input type="checkbox"/></li> <li>• Is the patient controlled with medication? YES <input type="checkbox"/> _____ NO <input type="checkbox"/></li> <li>• Recent arterial gases? YES <input type="checkbox"/> _____ NO <input type="checkbox"/></li> <li>• Does the patient retain CO2? YES <input type="checkbox"/> _____ NO <input type="checkbox"/></li> <li>• Have they required ventilatory support within last 14 days? YES <input type="checkbox"/> _____ NO <input type="checkbox"/></li> </ul>	
<b>2. CANCERS</b>	
<ul style="list-style-type: none"> <li>• Stage classification: <input type="checkbox"/> Stage I <input type="checkbox"/> Stage II <input type="checkbox"/> Stage III <input type="checkbox"/> Stage IV</li> <li>• Evidence of metastatic disease in brain, or lungs? YES <input type="checkbox"/> NO <input type="checkbox"/></li> <li>• Any evidence of seizures? YES <input type="checkbox"/> NO <input type="checkbox"/></li> <li>• Is respiratory disease or symptoms? YES <input type="checkbox"/> NO <input type="checkbox"/></li> <li>• Has there been a recent/ significant deterioration? YES _____ NO <input type="checkbox"/></li> <li>• Is the patient currently receiving chemotherapy? YES _____ NO <input type="checkbox"/></li> <li>• Patients short-term prognosis _____</li> <li>• Are there any compassionate reasons for travel? YES _____ NO <input type="checkbox"/></li> </ul>	
<b>3. NEUROLOGICAL</b>	
<ul style="list-style-type: none"> <li>• Does this patient have seizures? YES <input type="checkbox"/> _____ NO <input type="checkbox"/></li> <li>• When was the last seizure? _____</li> <li>• Frequency of seizures <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> More than 1 a month</li> <li>• Are the seizures controlled by medication? YES <input type="checkbox"/> _____ NO <input type="checkbox"/></li> <li>• Date of head injury: _____</li> <li>• Loss of consciousness? YES <input type="checkbox"/> _____ NO <input type="checkbox"/></li> <li>• Base of skull fracture <input type="checkbox"/> Subdural haematoma <input type="checkbox"/></li> <li>• Subarachnoid haemorrhage <input type="checkbox"/></li> <li>• Evidence of pneumocranium? YES <input type="checkbox"/> _____ NO <input type="checkbox"/></li> <li>• Evidence of CT scan cranium free of air? YES <input type="checkbox"/> _____ NO <input type="checkbox"/></li> <li>• _____</li> </ul>	
<b>4. PSYCHIATRIC (including drug and alcohol issues)</b>	
<ul style="list-style-type: none"> <li>• Does the patient a history of psychosis? YES <input type="checkbox"/> _____ NO <input type="checkbox"/></li> <li>• Is the patient a risk to themselves or others? YES <input type="checkbox"/> _____ NO <input type="checkbox"/></li> <li>• Does this patient have a history of violence? YES <input type="checkbox"/> _____ NO <input type="checkbox"/></li> <li>• Is the patient currently stable on medication? YES <input type="checkbox"/> _____ NO <input type="checkbox"/></li> <li>• Is the patient compliant to all reasonable instructions? YES <input type="checkbox"/> _____ NO <input type="checkbox"/></li> <li>• Is the passenger withdrawing from alcohol or other drugs? YES <input type="checkbox"/> _____ NO <input type="checkbox"/></li> </ul>	

