

## Follow this instructions to complete the MEDIF:

- 1 To start the procedure, make sure that you have a booking on an Aerolíneas Argentinas .
- 2 Complete the MEDIF's form (4 pages)  
Attachment A (1 page): to be completed and signed by passenger or adult in charge.  
Attachment B (part 1 & 2, 3 pages): must be completed, signed and stamped by your doctor.
- 3 Send the completed form by email to **producto@aerolineas.com.ar**
- 4 Contact us via WhatsApp (+ 54 9 11 4940 4798 - option 5 - Services / Specials Requests) to confirm that your email was received.
- 5 We will contact you to inform the results of MEDIF's evaluation.
- 6 On the day of your flight you must bring the original MEDIF and 2 copies, one to be handed in to the check in staff and the other one to the flight attendants.

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### Useful information:

We kindly ask you to fill in all the blanks in the MEDIF and in print letters.

The MEDIF must be sent at the latest 20 working days before and at least 72 working hours before the flight departure time.

We recommend your Doctor to attach all the relevant case information (clinical history, medical tests, etc.).

The Grupo Aerolíneas Medical Department may request additional information.

"We inform you that the personal information provided in the standard medical information form for air travel (MEDIF) shall be used by Aerolíneas Argentinas S.A. pursuant to the Argentine Personal Data Protection Regulations (Law 25326) and the General Data Protection Regulation of the European Union (2016/679).

The aim of this document is to allow the medical team of Aerolíneas Argentinas to assess the convenience of the passenger's trip, tending to his/her individual health conditions, and if needed, to provide relevant medical assistance. The legal basis for this treatment is your consent; please be aware that you will be asked to provide sensitive information in this form.

The information provided may be shared with third parties in order to ease your trip and provide you with adequate assistance, being this information necessary for such purposes.

The information will be kept for as long as necessary to fulfill the purpose for which it was collected, and to deal with the obligations that may arise from it. At any time, you will be able to exercise your rights of access or objection to, and/or rectification, deletion, portability or restriction of such information, by writing to Aerolíneas Argentinas España or by sending an email to [personaldata@aerolineas.eu](mailto:personaldata@aerolineas.eu) You must include a copy of your ID or similar official document for identification purposes.

We also inform you that you may turn to the Supervisory Authority in order to enforce your data protection rights.

Find more information on our Privacy Policy at [www.aerolineas.com](http://www.aerolineas.com)"

*Thank you for choosing us!*

# MEDIF ATTACHMENT A

Reso IATA 700

Information Sheet for the Passengers Requiring Assistance

Please fill out in clear and legible printing. mark an **X** in the corresponding boxes for your answer(s)

<b>1</b>	LAST NAME / FIRST NAME																															
<b>2</b>	PASSENGER NAME RECORD (6 LETTERS)											*	→ PROPOSED ITINERARY																			
<b>3</b>	<b>OUTBOUND</b> FLIGHT NUMBER	AR			DATE (of flight)					FROM:											TO:											
<b>↔</b>	<b>CONNECTING</b> FLIGHT NUMBER	AR			DATE (of flight)					FROM:											TO:											
	<b>RETURN</b> FLIGHT NUMBER	AR			DATE (of flight)					FROM:											TO:											
<b>4</b>	PASSENGER CONDITION: _____																															
<b>5</b>	STRETCHER NEEDED ON BOARD (NOT AVAILABLE) : Aerolíneas Argentinas <b>DOES NOT</b> TRANSPORT PASSENGERS ON STRETCHER																															
<b>6</b>	INTENDED ESCORTS	<input type="checkbox"/> NO	<input type="checkbox"/> Yes	*PASSENGER NAME RECORD (6 LETTERS)																(* IF IT'S DIFFERENT)	AGE											
<b>👤</b>	LAST NAME / FIRST NAME																															
<b>7</b>	WHEELCHAIR NEEDED ?																															
<b>♿</b>	<input type="checkbox"/> WCHR		Need a WheelChair to move through the airport / <b>can</b> climb stairs.....																									<input type="checkbox"/>				
	<input type="checkbox"/> WCHS		Need a WheelChair to move through the airport / <b>can't</b> climb stairs.....																									<input type="checkbox"/>				
	<input type="checkbox"/> WCHC		Need a WheelChair up to the seat on the plane.....																									<input type="checkbox"/>				
	OWN WHEELCHAIR ?																															
	<input type="checkbox"/> NO		<input type="checkbox"/> Yes	----- <input type="checkbox"/> CONTINUE										Please cross out not applicable options																		
	° TYPE OF PERSONAL WHEELCHAIR																															
	<input type="checkbox"/> MANUAL		<input type="checkbox"/> COLLAPSIBLE		<input type="checkbox"/> BATTERY		----- <input type="checkbox"/> CONTINUE																									
	° BATTERY TYPE:																															
	<input type="checkbox"/> **WET (WCBW)		<input type="checkbox"/> *GEL/DRY (WCBD)		<input type="checkbox"/> *LITHIUM (WCLB)												<small>** It is not accepted as luggage, only as cargo. * The passenger should complete the "Battery powered wheelchair statement" ( Attachment C, Chapter 7 M.C. )</small>															
<b>8</b>	AMBULANCE NEEDED : <b>DOES NOT</b> APPLY INSIDE THE AIRPORT.																															
<b>9</b>	MEET and ASSIST : DIFFERENT TO THE SERVICE PROVIDED BY Aerolíneas Argentinas WHEELCHAIR <b>DOES NOT</b> APPLY																															
<b>10</b>	OTHER GROUND ARRANGEMENTS NEEDED ? <input type="checkbox"/> NO <input type="checkbox"/> Yes																															
<b>✈</b>	DEPARTURE AIRPORT, Specify : _____																															
<b>✈</b>	TRANSIT AIRPORT, Specify : _____																															
<b>✈</b>	ARRIVAL AIRPORT, Specify : _____																															
<b>11</b>	SPECIAL INFLIGHT ARRANGEMENTS NEEDED ? <input type="checkbox"/> NO <input type="checkbox"/> Yes Specify : _____																															
<b>12</b>	FREQUENT TRAVELER MEDICAL CARD "FREMEC" EMITTED BY Aerolíneas Argentinas ?																															
<b>👤</b>	<input type="checkbox"/> NO <input type="checkbox"/> Yes		----- <input type="checkbox"/> COMPLET										NUMBER OF FREMEC CARD							VALID UNTIL					AGE			SEXO	M F			
<b>📄</b>	<p>PASSENGER AFFIDAVIT, The undersigned _____ domiciled at _____ acting on his/her own behalf or on behalf of the above named passenger, hereby states that he or she releases Aerolíneas Argentinas S.A. and its agents and employees from any liability arising from the alteration or deterioration of the passenger's health, serious injuries or any other consequence that could affect the passenger due to his or her health condition during or as a consequence of the flight arranged in the passenger's electronic ticket. Furthermore the undersigned undertakes to reimburse Aerolíneas Argentinas for any expenses incurred in connection with the provision of auxiliary services in addition to the air transportation service offered by the carrier and, therefore, releases the above mentioned carriers from any liability and/or payment of fees that may arise as a result of any additional services or assistance provided.</p>																															
	_____ / / _____																															
	Place & Date										.I.D./Passaport										Passenger Signature											

RESO IATA 700

Information sheet for passengers requiring medical clearance, to be completed by the attending physician. Please fill out in clear and legible printing. Mark with an **x** the boxes that correspond.

**MEDA 1**

PATIENT'S NAME

DATE OF BIRTH       GENDER   HEIGHT     WEIGHT

**MEDA 2**

ATTENDING PHYSICIAN

CONTACT TELEPHONE (indicate country and area code)

E-MAIL Address

**MEDA 3**

DIAGNOSIS (including date of onset of current illness, episode or accident and treatment) : \_\_\_\_\_

IS IT A CONTAGIOUS OR TRANSMISSIBLE DISEASE ?     Date of initiation: \_\_\_\_/\_\_\_\_/\_\_\_\_

CAN THE PASSENGER USE THE SEAT IN AN UPRIGHT POSITION WHEN REQUIRED ?

DOES THE PASSENGER NEED THE USE OF ANY SUPPORT / FASTENER SYSTEM IN THE SEAT TO KEEP THE TORSO IN UPRIGHT POSITION ?

NATURE AND DATE OF ANY RECENT AND/OR RELEVANT SURGERY \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**MEDA 4**

CURRENT SYMPTOMS AND SEVERITY: \_\_\_\_\_

**MEDA 5**

WILL A 25% TO 30% REDUCTION IN THE AMBIENT PARTIAL PRESSURE OF OXYGEN (RELATIVE HYPOXIA) AFFECT THE PASSENGER'S MEDICAL CONDITION? (CABIN PRESSURE BE THE EQUIVALENT OF A MOUNTAIN ELEVATION OF 8000 FEET -2400 METERS- ABOVE SEA LEVEL).

**MEDA 6**

ADDITIONAL CLINICAL INFORMATION:

**A- HEMATOLOGIC CONDITION**

ANEMIA:     If yes, give recent result in grams of hemoglobin \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

- Is, the patient under anticoagulant treatment for any reason?

**B- PSYCHIATRIC AND SEIZURE DISORDER ?**

**C- CARDIAC CONDITION**

**D- NORMAL BLADDER CONTROL?**

If no, give mode of control \_\_\_\_\_

**E- IS THE PATIENT ON DIALYSIS TREATMENT ?**

If yes, please attach the laboratory results after the last dialysis performed.

**F- NORMAL BOWEL CONTROL?**

**G- DOES THE PATIENT HAVE A SPECIAL RESPIRATORY CONDITION ?**

**H- DOES THE PATIENT USE OXYGEN AT HOME ?**

If yes, specify how much, amount and time of autonomy in hours without oxygen ? \_\_\_\_\_

**I- DOES THE PATIENT PLAN TO USE HIS / HER OWN PORTABLE OXYGEN CONCENTRATOR ON BOARD ?**

If yes, specify : BRAND: \_\_\_\_\_ MODEL: \_\_\_\_\_

**J- DOES THE PATIENT TRAVEL WITH OTHER RESPIRATORY ASSISTANCE MEDICAL DEVICES THAT WILL USE IN FLIGHT ?**

If yes, specify : **CPAP**  **BIPAP**  **VPAP**  **APAP**  **EPAP**

**IMPORTANT :** duration of the battery/ies in hours:

- FOR FLIGHTS OF LESS THAN 6 HOURS: AUTONOMY EQUAL TO 3 ADDITIONAL HOURS TO THE TOTAL LENGTH OF THE ITINERARY, INCLUDING STOPOVERS AND CONNECTIONS.
- FOR FLIGHTS OF MORE THAN 6 HOURS: AUTONOMY EQUAL TO 150% OF THE TOTAL LENGTH OF THE ITINERARY, INCLUDING STOPOVERS AND CONNECTIONS.

➤ *Continuation* Information sheet for passengers requiring medical clearance, to be completed by the attending physician. Please fill out in clear and legible printing. Mark with an **x** the boxes that correspond.

**MEDA 7** **ESCORT**

**A-** IS THE PATIENT FIT TO TRAVEL UNACCOMPANIED?  No  Yes

**B-** IF NO, WOULD A MEET AND ASSIST (PROVIDED BY THE AIRLINE TO EMBARK AND DISEMBARK), BE SUFFICIENT?  No  Yes

**C-** IF NO, WILL THE PATIENT HAVE A PRIVATE ESCORT TO TAKE CARE OF HIS/HER NEEDS ON BOARD?  No  Yes

**D-** IF YES, WHO SHOULD ESCORT THE PASSENGER? \_\_\_\_\_ **NURSE**  **DOCTOR**  **OTHER**  \_\_\_\_\_

**E-** IF OTHER, IS THE ESCORT FULLY CAPABLE TO ATTEND TO ALL THE ON BOARD NEEDS?  No  Yes

**MEDA 8** **MOBILITY**

**A-** CURRENTLY HAVE A BONE FRACTURE: \_\_\_\_\_ (\* if yes, see Part 2)  No  Yes

**B-** ABLE TO WALK WITHOUT ASSISTANCE: \_\_\_\_\_  No  Yes

**C-** WHEELCHAIR REQUIRED FOR BOARDING: \_\_\_\_\_  No  Yes \*

(\* IF YES) TO AIRCRAFT:  No  Yes TO SEAT:  No  Yes

**MEDA 9** **MEDICATION LIST**

LIST OF MEDICATION OF THE PATIENT AND FORM OF ADMINISTRATION (UNDER THE SOLE RESPONSIBILITY OF THE PATIENT / COMPANION)

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

Note: \_\_\_\_\_

**MEDA 10** **ADDITIONAL MEDICAL INFORMATION ABOUT PATHOLOGY, COMORBIDITIES, USE OF PROBES, CATHETERS OR OTHER DEVICES AND / OR CONDITIONS THAT MAY BE RELEVANT DURING AIR TRANSPORT.**

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NOTE : Cabin attendants are not authorized to give special assistance (e.g. lifting) to particular passengers, to the detriment of their service to other passengers. Additionally, they are trained only in first aid and are not permitted to administer any injection, or to give medication. **Important:** Fees, if any, relevant to the provision of the above information and form carrier-provided special equipment are to be paid by the passenger concerned.

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Information sheet for passengers requiring medical clearance, to be completed by the attending physician. Please fill out in clear and legible printing. Mark with an **x** the boxes that correspond.

MEDA 1

### CARDIAC CONDITION

**A- ANGINA**  No  Yes  IF YES, WHEN WAS THE LAST EPISODE? \_\_\_\_ / \_\_\_\_ / \_\_\_\_ IS THE CONDITION STABLE?  No  Yes

FUNCTIONAL CLASS OF THE PATIENT → NO SYMPTOMS  ANGINA WITH LIGHT EFFORTS  ANGINA WITH IMPORTANT EFFORTS  ANGINA AT REST

CAN THE PATIENT WALK 100 METERS AT A NORMAL PACE OR CLIMB 10-12 STAIRS WITHOUT SYMPTOMS?  No  Yes

**B- MYOCARDIAL INFARCTION**  No  Yes  DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ COMPLICATIONS?  No  Yes  (\*IF YES, GIVE DETAILS)

\* \_\_\_\_\_

**STRESS EKG DONE?**  No  Yes  IF YES, WHAT WAS THE RESULT? \_\_\_\_\_ METZ.

\* IF ANGIOPLASTY OR CORONARY BYPASS, CAN THE PATIENT WALK 100 METERS AT A NORMAL PACE OR CLIMB 10-12 STAIRS WITHOUT SYMPTOMS?  No  Yes

**C- CARDIAC FAILURE**  No  Yes  WHEN WAS LAST EPISODE? \_\_\_\_ / \_\_\_\_ / \_\_\_\_ IS CONTROLLED WITH MEDICATION?  No  Yes

FUNCTIONAL CLASS OF THE PATIENT → NO SYMPTOMS  SHORTNESS OF BREATH: WITH IMPORTANT EFFORTS  WITH LIGHT EFFORTS  BREATH AT REST

**D- SYNCOPE**  No  Yes  WHEN WAS LAST EPISODE? \_\_\_\_ / \_\_\_\_ / \_\_\_\_ INVESTIGATIONS?  No  Yes  (\* IF YES, STATE RESULTS)

\* \_\_\_\_\_

MEDA 2

**CHRONIC PULMONARY CONDITION**  No  Yes

**A- HAS THE PATIENT HAD RECENT ARTERIAL GASES?**  No  Yes

**B- BLOOD GASES WERE TAKEN ON:** ROOM AIR  OXIGEN  LPM

IF YES, WHAT WERE THE RESULTS: **PCO2** \_\_\_\_\_ **PO2** \_\_\_\_\_

SATURATION \_\_\_\_\_ DATE OF EXAM: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**C- DOES THE PATIENT RETAIN CO2?**  No  Yes

**D- HAS HIS/HER CONDITION DETERIORATED RECENTLY?**  No  Yes

**E- CAN THE PATIENT WALK 100 METERS AT A NORMAL PACE OR CLIMB 10-12 STAIRS WITHOUT SYMPTOMS?**  No  Yes

**F- HAS THE PATIENT EVER TAKEN A COMMERCIAL AIRCRAFT IN THESE SAME CONDITIONS?**  No  Yes  → DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

DID THE PATIENT HAVE ANY PROBLEMS? \_\_\_\_\_

MEDA 3

**PSYCHIATRIC CONDITIONS**

**A- IS THERE A POSSIBILITY THAT THE PATIENT WILL BECOME AGITATED DURING FLIGHT?**  No  Yes

**B- HAS HE/SHE TAKEN A COMMERCIAL AIRCRAFT BEFORE?**  No  Yes  → DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

DID THE PATIENT TRAVEL: ALONE  ESCORTED

MEDA 4

**SEIZURE**  No  Yes

**A- WHAT TYPE OF SEIZURE?** \_\_\_\_\_

**B- FREQUENCY OF THE SEIZURES** \_\_\_\_\_ WHEN WAS THE LAST SEIZURE? \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**C- ARE THE SEIZURES CONTROLLED BY MEDICATION?**  No  Yes

MEDA 5

**PROGNOSIS FOR THE TRIP:** GOOD  REGULAR  BAD

MEDA 6

**MOBILITY AND LOCOMOTOR SYSTEM**

SPECIFY FRACTURED BONE \_\_\_\_\_

DATE OF THE FRACTURE \_\_\_\_ / \_\_\_\_ / \_\_\_\_

IS CURRENTLY PLASTERED?  No  Yes  → WHEN WAS IT PLASTERED? \_\_\_\_ / \_\_\_\_ / \_\_\_\_

IS THE PLASTERED SPLIT?  No  Yes

NOTE: Cabin attendants are not authorized to give special assistance (e.g. lifting) to particular passengers, to the detriment of their service to other passengers. Additionally, they are trained only in first aid and are not permitted to administer any injection, or to give medication. **Important:** Fees, if any, relevant to the provision of the above information and form carrier-provided special equipment are to be paid by the passenger concerned.

Place and Date

PHYSICIAN SIGNATURE