Airborne Rescue Society
www.airbornerescue.org

Mission Guidelines Form

Patient's Name: ____

Parent/or Legal Guardian Name: __________________________________

Date:___________________

Contact name, phone # & relationship to patient:

All patients must agree to the following before being accepted for air transportation:
(Place Check-mark indicating understanding and compliance.)

_______ 1. Patient is able to walk & climb steps without assistance (unless the patient is a child under 6 years old) and is medically stable.

_______ 2. Patient service is not available locally nor can patient endure lengthy ground transportation.

_______ 3. Patient/family can not afford commercial air transportation for treatments.

_______ 4. Patient is able to ride in a small, non-pressurized airplane that is not equipped for medical emergencies.

_______ 5. Patient will provide own ground transportation to airport for departure & from the airport to treatment center.

_______ 6. Patient will provide a physician that has recently seen the patient that will authorize travel. We will need their name & fax number within 24 hours of intake.

_______ 7. All passengers must agree to sign a waiver at airport before departure.

______ 8. Agree not to exceed our baggage weight limit of forty (40 Pounds), & understand that the mission cannot fly if limit is violated.

_______ 9. Understand that weather can affect the ability to complete missions.

_______ 10. Notify us if your appointment cancels or if you make other travel plans and do not need our service.

_____________________________ _______________________

Name (Signature) Date

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(Printed)