



# DREAMS TAKE FLIGHT

## FITNESS FOR TRAVEL MEDICAL INFORMATION

TO BE COMPLETED BY THE PHYSICIAN (PLEASE PRINT)

### Child Information

Child's Last Name: \_\_\_\_\_ Child's First Name: \_\_\_\_\_

Age at time of flight (November 4, 2026): \_\_\_\_\_ Height: \_\_\_\_\_ cm / in Weight: \_\_\_\_\_ kg / lbs

### Medical Information

1. Medical impairment(s) / Diagnosis

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2. Present Symptoms and limits to activity

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3. Hospitalization (if applicable)  Yes  No

Date of last hospitalization: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

4. Cabin Pressure Considerations

Will a **25% to 30% reduction in the ambient partial pressure of oxygen** affect the child's medical condition?  
(Cabin pressure can be equivalent to a rapid ascent to approximately 8,000 ft / 2,400 m above sea level)

Yes  No

5. Activity Tolerance

Can this child sustain **one full day of activity at Disney World**?  Yes  No

If no, please specify:

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6. Allergies

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7. Medications (list by name and dosage)

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Can this child take his/her own medications?  Yes  No

If no, please specify:

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8. Special Considerations (i.e. feeding, catheterization, incontinence, mobility aids, motion sickness, etc.)

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9. Please Specify

a. **Anemia?**  Yes  No If yes, give Hemoglobin: \_\_\_\_\_

b. **Heart failure?**  Yes  No

c. **Shortness of breath?**  None  At rest  On exertion

If on exertion, please specify: \_\_\_\_\_

d. **Supplemental oxygen needed while flying?**  Yes  No

e. **Does this child require any medical treatments during this trip?**  Yes  No

If yes, please specify: \_\_\_\_\_

10. Diapers/Pull-ups

Should this child wear diapers or pull-ups during the day?  Yes  No

11. Mobility

Is the child ambulatory and capable of boarding the aircraft or ambulating within the aisle with assistance?

Yes  No

If the child is not already in a wheelchair, is a wheelchair required for this trip?  Yes  No

If no, is the child able to stand for **30 minutes**?  Yes  No



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### 12. Psychiatric /Behavioral Conditions

ADD:  Yes  No With hyperactivity:  Yes  No Autism:  Yes  No **Degree:** \_\_\_\_\_

If other psychiatric / behavioral condition, please specify:

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### 13. Group Participation

Is this child able to **participate and cooperate in a small group (maximum 8 children)** during a very busy day?  Yes  No

If no, why?

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### 14. Neurological Conditions

**Seizures:**  Yes  No

If yes, specify frequency, characteristics, method of control/abortion, and date of last seizure:

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**Developmental Delay:**  Yes  No

If other neurological condition, please specify:

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### 15. Additional Information

Any information relevant to the child's ability to travel

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### Physician Information

Attending Physician Name: \_\_\_\_\_ License Number: \_\_\_\_\_

Telephone #: \_\_\_\_\_

Signature of physician: \_\_\_\_\_ Date: \_\_\_\_\_

#### Dreams Take Flight – Physician Review

Approved

Not Approved

Deferred pending more information