

**MEDICAL FITNESS CERTIFICATE**

|  |                                |  |
|--|--------------------------------|--|
| Name   |                                |  |
| DOB and Age  |                                |  |
| Residential Address  |                                |  |
| Blood Group  |                                |  |
| Weight   |                                |  |
| Pulse Rate   |                                |  |
| Blood Pressure   |                                |  |
| Condition of upper and lower limbs, fingers, feet and toes – details of physical disability, recent injury if any observed.      |                                |  |
| Vision, hearing – normal / any deviation from normal if observed.  |                                |  |
| If suffering from any of the problems mentioned alongside.<br>Please specify as Yes / No.<br>Please provide more details if Yes. | Hypertension                   |  |
|  | Diabetes                       |  |
|  | Asthma                         |  |
|  | Epilepsy                       |  |
|  | Infectious disorders           |  |
|  | Heart diseases                 |  |
|  | Any other recent major illness |  |
| Any known allergies to drugs, medicines or food items.   |                                |  |
| Any prior history of high altitude sickness, Acute Mountain Sickness, HAPE, HACE   |                                |  |
| If under any medication currently – details of medication and reason for being prescribed the same.                              |                                |  |

I, Dr. \_\_\_\_\_, have carefully examined the person, whose name, address and other details are as tabulated above, and declare that he / she is physically and medically fit to participate in a high altitude trek and is not suffering from any chronic illness.

Signature of Applicant

Signature of Medical Officer

Place:

Reg. No.

Date:

Office Seal