

MEDICAL FITNESS CERTIFICATE

(To be filled by a Registered Medical Practitioner- MBBS or above)

Patient Name: _____ Age: _____
Gender: _____ Blood Group: _____

General Examination:

Pulse Rate: _____ / min

Blood Pressure: _____ / _____ mmHg

Respiratory Rate: _____ / min

SpO2 (Oxygen Level): _____ %

Drug Allergies (if any): _____

History of Illness (Yes/No):

Heart Disease / Hypertension: []

Asthma / Breathlessness: []

Diabetes: []

Epilepsy / Seizures: []

Doctor's Certification:

I have examined Mr./Mrs. _____ and
found him/her FIT to undertake a high-altitude trek/journey
to Adi Kailash (approx. 15,000 ft) & Om Parvat.

Doctor's Name: _____

Signature & Seal: _____

Date: _____

Adi Kailash Devnagri

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