COMPULSORY HEALTH CERTIFICATE FOR ADVENTURE ACTIVITY

Paste recent passport size photograph

Part A: (To be filled by the participant)

1. Name: ____
2. S/o. D/o. W/o: __________________________________
3. Address:____
   ____
4. Date Of Birth: ___,___,______ Aadhar No.: ___________________ Blood Group: ______
5. Identification mark: ____

Age limit:
- A) The traveler should not be less than 18 years or more than 65 years old.
- B) Any lady with pregnancy with or more than 6 weeks is suggested not to register.

6. Declaration: Do you have the history or suffered from any of the following:

S. No	Condition	Y	N	S. No	Condition	Y	N
1	Diabetes			9	Epilepsy		
2	Blood pressure			10	Nervous breakdown		
3	Blood disorder			11	Joint pains		
4	Bleeding Tendencies			12	High altitude sickness		
5	Breathlessness			13	Discharge from ear		
6	Asthma			14	History of stroke/paralysis		
7	Lung/respiratory ailments			15	Smoker		
8	Heart ailment			16	Pregnant		

- Heart attack history (if Yes, please specify) _________________________________
- History of sudden demise of family (if Yes, please specify) ___________________
- Any significant past injuries (if yes, please specify) _________________________
- Any other ailment (if Yes, please specify) _________________________________
- Any surgical history (if Yes, please specify) ________________________________
- Any present medication (if Yes, please specify) _____________________________
- Any allergy to drugs, food, chemical (if Yes, please specify) ___________________

I hereby declare that the details shared above are true to the best of my knowledge and belief, nothing has been concealed.

Date: ___, ___, ________ (Signature/Thumb impression of traveler)

PART B: (TO BE FILLED BY CERTIFIED MEDICAL PRACTITIONER)

On the basis of the information shared above by the applicant and after detailed examination of the prescribed necessary investigation reports dated ____, ____, ________. It is certified that **Mr/ Ms. / Mrs.** ____ is fit to undertake the adventure activity/journey.

Details of any specific medical test concluded before issuing the certificate: ____

Name of the Doctor: ________________________________

Specialization: ______________________________

Date of issue: ____, ____, ________

MCI/State Medical Council registration No.: ______________________________

Seal & Signature of Doctor