

COMPULSORY HEALTH CERTIFICATE FOR Kinnaur Kailash Yatra 2024

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recent passport size
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PART A (TO BE FILLED BY APPLICANT)

1. Name _____ S/o.D/o.W/o _____
Address _____
2. Date of Birth _____ Identification mark- _____ Blood group _____

DECLARATION: Have you suffered from or have history of any of the following:

- | | | | |
|-----------------------------|--|---|--|
| a) Breathlessness | <input type="checkbox"/> Yes <input type="checkbox"/> No | b) Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c) Respiratory/lung ailment | <input type="checkbox"/> Yes <input type="checkbox"/> No | d) High Blood pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e) Blood disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | f) Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| g) Bleeding tendencies | <input type="checkbox"/> Yes <input type="checkbox"/> No | h) Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| i) Heart ailments | <input type="checkbox"/> Yes <input type="checkbox"/> No | i) Nervous breakdown | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| k) Joint Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | l) High altitude/mountain sickness | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| m) Discharge from ear | <input type="checkbox"/> Yes <input type="checkbox"/> No | n) History of stroke paralysis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| o) Are you a smoker | <input type="checkbox"/> Yes <input type="checkbox"/> No | p) Are you pregnant
(applicable to female yatries) | <input type="checkbox"/> Yes <input type="checkbox"/> No |

- q) History of Heart Attack, if yes, please specify _____
r) History of sudden death in family members if yes please specify _____
s) Any major injury in the past, if yes please specify, _____
t) Any other ailment, if yes, please specify _____
u) History of surgery, if yes, please specify _____
v) Are you under any medication. if yes, please specify _____
w) Are you allergic to drugs, foods and chemicals if yes, please specify, _____

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

Dated:- _____

Signature/thumb impression of the Applicant

PART B: (TO BE FILLED BY AUTHORISED MEDICAL AUTHORITY)

Pulse:

BP:-

Spo2

On the basis of information furnished by the applicant, detailed examination and the necessary investigations, it is certified that Mr./Ms./Mrs. _____ is fit to undertake the journey to the Kinnaur Kailash Yatra

Details of any specific test (if any) conducted before issuing the certificate: _____

Name of the Doctor: - _____

Designation: - _____

Date of issue: - _____

Signature and seal of Authorized Medical Authority
(Registered Medical Practitioner)