Date: [Insert Date]

Patient Name: [Insert Patient Full Name]
Date of Birth: [Insert Date of Birth]
Passport Number (Optional): [Insert Number]

To Whom It May Concern,

I am the primary healthcare provider for the patient named above. I have performed a clinical evaluation and reviewed their medical history in preparation for their upcoming travel to a high-altitude destination ([Insert Destination/Altitude, e.g., 4,000m+]).

Based on my assessment, the patient has no known medical contraindications to high-altitude trekking or travel. Their cardiovascular and respiratory systems appear stable for the physical demands associated with this elevation.

Current Medications:
[List medications or write "None"]

Prophylactic Medications Prescribed:
[e.g., Acetazolamide/Diamox or write "N/A"]

Medical Clearance Status:
The patient is cleared for travel to high altitudes. They have been advised on the symptoms of Acute Mountain Sickness (AMS), High Altitude Pulmonary Edema (HAPE), and High Altitude Cerebral Edema (HACE), and instructed on the necessity of gradual ascent and hydration.

Please feel free to contact my office at [Insert Phone Number] if you require further information.

Sincerely,

[Physician Signature]

Physician Name: [Insert Name]
Medical License Number: [Insert License Number]
Clinic/Hospital Name: [Insert Facility Name]
Contact Information: [Insert Email/Phone]