[Physician Name]
[Clinic/Hospital Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Date]

To Whom It May Concern,

RE: Medical Clearance for High Altitude Travel

Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]

This letter serves to certify that [Patient Name] is currently under my care for the management of asthma. I have reviewed the patient's medical history and current respiratory status regarding their upcoming travel to [Destination/Altitude].

As of my last evaluation on [Date of Last Exam], the patient's asthma is considered stable and well-controlled. In my professional opinion, the patient is medically cleared to travel to and stay at high altitudes, provided they adhere to their prescribed medication regimen.

The patient has been instructed to:

- Carry their rescue inhaler ([Inhaler Name]) at all times.
- Continue use of maintenance medications ([Medication Names]) as prescribed.
- Monitor for symptoms such as increased shortness of breath, wheezing, or chest tightness.
- Seek immediate medical attention if symptoms do not respond to rescue medication.

If you require further information regarding this patient's medical condition, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]
[Medical License Number]