

**Date:** [Insert Date]

**To:** [Mission Organization Name/Medical Review Board]

**Subject:** Medical Clearance for High-Altitude Mission Trip

**Patient Name:** [Insert Patient Full Name]

**Date of Birth:** [Insert Date of Birth]

To Whom It May Concern,

I have performed a physical examination on the above-named patient to evaluate their fitness for a mission trip to [Insert Destination], which involves altitudes of approximately [Insert Altitude] feet/meters above sea level.

My evaluation included a review of the patient's medical history, current medications, and a physical assessment of their cardiovascular and respiratory health. Based on this evaluation, I find the patient to be:

**Medically Cleared:** The patient has no known contraindications to high-altitude travel and is physically capable of participating in the planned activities.

**Cleared with Restrictions:** The patient is cleared to participate provided the following conditions or limitations are met:  
[Insert Restrictions Here]

**Not Cleared:** The patient is not medically cleared for high-altitude travel at this time.

**Medication Notes:**

The patient has been advised on the use of [Insert Medication, e.g., Acetazolamide] for altitude sickness prevention, if applicable. They are also carrying a sufficient supply of their regular maintenance medications.

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

Sincerely,

**Physician Signature:** \_\_\_\_\_

**Physician Name:** [Insert Printed Name]

**Medical License Number:** [Insert License Number]

**Clinic/Hospital Name:** [Insert Clinic Name]

**Address:** [Insert Address]