Date: [Date]

To: [Flight School Name / Paragliding Association]

Medical Assessment for Paragliding

Patient Name: [Patient Full Name]

Date of Birth: [Patient Date of Birth]

To whom it may concern,

I have examined the above-named patient for the purpose of assessing their fitness to participate in paragliding activities. My assessment included a review of their medical history and a physical examination focused on the physical and psychological demands of the sport.

The patient has been assessed for the following criteria:

- Cardiovascular and respiratory health.
- Neurological stability (absence of seizures or sudden incapacitation).
- Musculoskeletal function and mobility.
- Visual and auditory acuity.
- Mental health and cognitive function.

Assessment Result:

[ ] I find no medical contraindications to the patient participating in paragliding.

[ ] I find the patient fit for paragliding with the following restrictions: [List restrictions or N/A]

[ ] I do not recommend the patient participate in paragliding at this time.

This assessment is valid until: [Expiry Date, e.g., 2 years from now].

Sincerely,

Signature: _____
Doctor Name: [Doctor Full Name]
Medical License Number: [License #]
Clinic/Hospital: [Facility Name]
Contact Information: [Phone/Email]

[Official Stamp/Seal]