



International Adventure Foundation

Web : www.iafadventures.com | E-Mail : iafkota1@gmail.com

Contact : +91 8890655098 , +91 7014520917

Medical Certificate

Name

Address

Date of birth / / Single/Married E-mail

1. Present/Past illness Significance

2. Injuries/Operations undergone and present condition

3. Any Known allergy to drugs or food stuff

4. Blood Group

Is the applicant suffering from

- | | | |
|-----------------------------|--------|--------------------------|
| A) Any infectious disease | Yes/No | <input type="checkbox"/> |
| B) Any skin disease | Yes/No | <input type="checkbox"/> |
| C) Mental disease | Yes/No | <input type="checkbox"/> |
| D) Heart Trouble | Yes/No | <input type="checkbox"/> |
| E) Asthma | Yes/No | <input type="checkbox"/> |
| F) Any other disease/defect | Yes/No | <input type="checkbox"/> |

5. I, on this date / / have examined Mr./Miss/Mrs and found him/her medically fit/unfit to undergo an Adventure programme in mountains.

Medical Officer Reg. No & Designation

Date : / /

Medical Officer
Seal & Signature

Risk Certificate

(for use of applicant below 18 years of age)

It is certified that my son/daughter _____ is joining the above mentioned Adventure Programme with my consent and the organizer shall not be responsible for any illness, injury or accident during the event or journey periods for the purpose. It is further certified that he/she is physically fit to undergo the IAIHS Adventure Programme.

Signature of Parent/Guardian

Relationship with participant _____ Name _____

Address _____

Date : _____ Mobile No : _____ E-Mail : _____

Note : Medical Examination should be done by a doctor and if any criteria, as given in the medical certificate form is not summit, the person will be declared medically unfit.