Date: [Date]

To: Scuba Diving Instructor / Dive Center Operations

Subject: Medical Clearance for Scuba Diving (Minor Patient)

Patient Name: [Child's Full Name]
Date of Birth: [MM/DD/YYYY]
Age: [Age]

To whom it may concern,

I have medically evaluated the patient named above regarding their physical and psychological fitness to participate in recreational scuba diving. My evaluation included a review of the WRSTC Medical Statement and a physical examination focused on the respiratory, cardiovascular, and neurological systems, as well as the patency of the Eustachian tubes.

Based on my findings, I certify that:

- The patient is physically fit to perform scuba diving activities.
- The patient demonstrates the emotional and cognitive maturity required to follow safety protocols and manage underwater stressors.
- There are no contraindications identified that would prevent the patient from diving within the depth and supervision limits set for their age group by [Training Agency, e.g., PADI/NAUI].

Conditions/Restrictions (if any): [None or specify restrictions]

I find no medical conditions that are incompatible with scuba diving at this time.

Sincerely,

[Physician Signature]

Physician Name: [Name and Title]
Medical License Number: [License #]
Clinic/Hospital Name: [Clinic Name]
Phone Number: [Phone Number]
Email: [Email Address]