Date: [Date]

To: [Foster Care Agency Name]
Address: [Agency Address]
City, State, Zip: [City, State, Zip]

RE: Medical Clearance for Foster Care Applicant

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

To Whom It May Concern,

I have completed a physical examination of the above-named individual on [Date of Exam]. The purpose of this evaluation is to determine their physical and mental fitness to serve as a foster parent.

Based on my clinical findings and the patient's medical history, I have determined the following:

- The applicant is free from communicable diseases that would pose a risk to children in their care.
- The applicant does not have any physical or mental health conditions that would impair their ability to provide adequate care, supervision, and a safe environment for foster children.
- The applicant is physically capable of performing the daily tasks required for childcare, including lifting and responding to emergencies.

Physician's Comments (if any):
[Insert comments or "None"]

In my professional opinion, [Applicant Name] is medically cleared to be a foster parent.

Sincerely,

[Physician Signature]
Physician Name: [Printed Name]
Medical License Number: [License #]
Clinic/Office Name: [Clinic Name]
Phone Number: [Phone Number]