Date: [Date]

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

RE: Medical Clearance for Foster Care Applicant

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

To Whom It May Concern,

I have performed a physical examination of the above-named individual on [Date of Examination]. The purpose of this evaluation was to determine the applicant's physical and mental fitness to serve as a foster parent.

Based on the clinical history and physical findings, I find that the applicant:

- Is free from communicable diseases that would pose a risk to children.
- Is physically capable of caring for children, including the ability to perform tasks such as lifting, responding to emergencies, and providing daily supervision.
- Is mentally and emotionally stable to undertake the responsibilities of foster parenting.
- Does not have any medical conditions or medications that would impair their judgment or ability to provide a safe environment.

Physician's Conclusion:

[ ] The applicant is medically cleared to be a foster parent without restrictions.

[ ] The applicant is cleared with the following limitations or recommendations: [Notes]

If you require any further information, please contact my office at [Phone Number].

Sincerely,

_____
Physician Signature

Physician Name: [Name/Title]
Medical License #: [License Number]
Clinic Name: [Facility Name]
Address: [Facility Address]