Date: [Date]

To: [Child Welfare Agency Name]
Address: [Agency Address]
Case Worker: [Name of Case Worker]

Subject: Medical Clearance for Kinship Foster Care Provider

To Whom It May Concern,

I am a licensed healthcare professional, and I am currently treating **[Patient Name]**, born on **[Patient Date of Birth]**.

I have performed a physical examination of the patient on **[Date of Exam]**. Based on my evaluation, I find the patient to be in good physical and mental health. There are no signs of communicable diseases that would pose a risk to others in the household.

It is my professional opinion that [Patient Name] is physically and emotionally capable of providing daily care, supervision, and a safe environment for a child in kinship foster care. The patient has no medical conditions or limitations that would interfere with their ability to perform the duties of a foster parent.

Required Health Information:

- Tuberculosis (TB) Test Result: [Result/Date]
- Immunization Status: [Up to date / Exempt]
- Current Medications: [None / List if applicable]

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

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Medical License Number]
[Clinic/Office Name]
[Office Address]