**Date:** [Date]

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

**RE: Medical Clearance for Respite Foster Care Applicant**

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

To Whom It May Concern,

I am a licensed healthcare professional, and I have completed a physical examination of the individual named above on [Date of Examination].

Based on my clinical evaluation, I find that the applicant is in good physical and mental health. They are free from communicable diseases that would pose a risk to children in their care. Furthermore, I have found no medical conditions or physical limitations that would interfere with their ability to provide safe and adequate respite care for children.

The applicant is physically capable of performing the following tasks:

- Lifting and carrying young children (if applicable).
- Responding quickly to emergencies.
- Managing the daily physical demands of childcare.

**Current Medications:** [None / List Medications]
**Special Considerations:** [None / List Considerations]

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

Sincerely,

**Provider Signature:** _____

**Provider Name (Printed):** [Name and Title]
**Medical License Number:** [License Number]
**Clinic/Facility Name:** [Clinic Name]
**Phone Number:** [Phone Number]