Date: [Insert Date]

To: [Foster Care Agency/Department Name]
Address: [Agency Address]
Re: Medical Clearance for Emergency Foster Care Placement

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

To Whom It May Concern,

I am a licensed physician and have been the primary healthcare provider for **[Applicant Name]** since **[Date/Year]**. I recently performed a physical examination on the patient on **[Date of Exam]**.

Based on my clinical evaluation, I find the patient to be in good physical and mental health. There are no known contagious diseases or medical conditions that would interfere with their ability to provide safe and stable care for a child in an emergency foster care capacity.

Specifically, I can confirm the following:

- The patient is free from communicable diseases.
- The patient is physically capable of performing childcare duties, including lifting and emergency response.
- The patient is mentally and emotionally stable to handle the stresses of emergency placement.
- Current medications (if any) do not impair the patient's judgment or motor skills.

I recommend **[Applicant Name]** for medical clearance as an emergency foster parent without restrictions.

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

Sincerely,

Physician Signature: _____

Physician Name: [Print Name]
Medical License #: [License Number]
Clinic/Facility Name: [Clinic Name]
Phone: [Phone Number]