**[Clinic or Hospital Letterhead]**
[Doctor's Name/Department]
[Address]
[Phone Number]
[Date]

**TO:** [Cruise Line Name] Medical Department / Terminal Staff

**RE:** Medical Clearance for Cruise Travel

**Patient Name:** [Child's Full Name]
**Date of Birth:** [MM/DD/YYYY]
**Dates of Travel:** [Start Date] to [End Date]

To Whom It May Concern,

I am the primary healthcare provider for [Child's Name]. I have reviewed the patient's medical history and current health status regarding their upcoming cruise travel.

At this time, I certify that the patient is in good health and has no known physical or mental conditions that would prevent them from traveling or participating in standard cruise activities. The patient is fit for travel and does not pose a health risk to other passengers or crew.

**Medical Details (if applicable):**

- **Known Allergies:** [List allergies or state "None"]
- **Chronic Conditions:** [List conditions or state "None"]
- **Required Medications:** [List medications to be carried on board]
- **Special Requirements:** [Dietary needs, mobility aids, or "None"]

The patient is up to date on all routine childhood immunizations recommended for their age.

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

Sincerely,

[Doctor's Signature]
[Doctor's Printed Name]
[Medical License Number]
[Clinic Stamp]