Date: [Insert Date]

To: [Insert Organization Name/Mission Trip Coordinator]

RE: Medical Clearance for [Patient Full Name]
Date of Birth: [Patient Date of Birth]

To Whom It May Concern,

I am the primary care physician for [Patient Full Name]. I have reviewed the patient's medical history and performed a physical examination on [Date of Last Exam].

Based on my evaluation, the patient is in good health and has no medical contraindications to participating in the upcoming mission trip to [Location] from [Start Date] to [End Date].

The following medical information is provided for your records:

- **Immunizations:** The patient is up-to-date on all routine childhood vaccinations. In preparation for this trip, the patient has also received: [List specific travel vaccines, e.g., Typhoid, Yellow Fever, Hep A].
- **Chronic Conditions:** [None / or list conditions such as Asthma, Allergies].
- **Current Medications:** [None / or list medications, dosages, and frequencies].
- **Allergies:** [None / or list Food, Medication, or Environmental allergies].

The patient is cleared for full participation in all activities associated with this mission, including international travel and physical labor, without restrictions.

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

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Clinic/Practice Name]
[Address]
[Phone Number]