Date: [Insert Date]

To: [Foster Care Agency Name]
Address: [Agency Address]
Re: Medical Certification for Foster Placement

Patient Name: [Child's Full Name]
Date of Birth: [Child's Date of Birth]

To Whom It May Concern,

I am a licensed physician currently providing medical care for the above-named child. I performed a comprehensive physical examination on [Date of Examination].

Based on this evaluation, I certify the following:

- The child is in good general health and is free from communicable diseases that pose a risk to others.
- The child's immunization record is [Up to date / In progress].
- The child has the following known allergies: [List Allergies or state "None"].
- The child is currently prescribed the following medications: [List Medications or state "None"].
- The child has the following chronic conditions or special needs: [List Conditions or state "None"].

In my professional opinion, this child is medically cleared for placement in a foster care setting. There are [No / The following] specific medical restrictions regarding their daily activities or caregiving requirements: [List Restrictions if applicable].

Please contact my office at [Phone Number] if you require further documentation or clarification.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Medical License Number]
[Clinic/Hospital Name]