Date: [Date]

To: [Foster Care Agency Name]
Address: [Agency Address]
Re: Pediatric Health Clearance for Foster Care Placement

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

To Whom It May Concern,

I have personally examined [Child's Name] on [Date of Examination]. Based on this clinical evaluation and a review of the patient's medical history, I find the child to be in good physical and mental health, and free from any communicable diseases.

Medical Summary:

- **Immunizations:** [Up to date / Scheduled] according to the CDC pediatric guidelines.
- **Growth and Development:** [Normal / Specific findings] for age.
- **Chronic Conditions:** [None / List conditions].
- **Current Medications:** [None / List medications].
- **Allergies:** [None / List allergies].

Clearance Statement:

The child is medically cleared for placement in a foster care setting without restrictions. [Optional: Additional recommendations for care].

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

Sincerely,

Physician Signature: _____

Physician Name: [Name and Title]
Medical License Number: [License #]
Clinic Name: [Clinic Name]
Phone: [Phone Number]