Date: [Insert Date]

To: [Healthcare Provider Name / Clinic Name]
Address: [Provider Address]

RE: Comprehensive Health Screening for Foster Child

Child's Name: [Child's Full Name]
Date of Birth: [Child's DOB]
Case Number: [Case ID Number]

Dear Doctor,

The child named above has recently entered foster care and is required to undergo a comprehensive health screening within [Number] days of placement. Please perform a full physical examination and assessment in accordance with the following requirements:

- Full physical examination (height, weight, BMI, vitals).
- Review of immunization records and administration of any required vaccines.
- Developmental and behavioral health screening.
- Vision and hearing screenings.
- Laboratory tests as clinically indicated (e.g., lead screening, TB test, blood work).
- Dental and oral health check.

Please provide a written summary of the findings, including any diagnosed conditions, prescribed medications, and recommended follow-up care or specialist referrals. This documentation is essential for the child's case file and to ensure continuity of care.

Consent for treatment is provided by: [Department of Social Services / Name of Legal Guardian].

Please send all medical reports and billing invoices to:

[Caseworker Name]
[Agency Name]
[Phone Number]
[Email Address]

Thank you for your assistance in ensuring this child's health and well-being.

Sincerely,

[Your Signature]
[Your Printed Name]
[Your Title/Relationship to Child]