Date: [Insert Date]

To: [Agency Name / Department of Social Services]
Address: [Agency Address]
City, State, Zip: [City, State, Zip Code]

RE: Immunization and Medical Clearance for Foster Care

Patient Name: [Child or Applicant Name]
Date of Birth: [Date of Birth]

To Whom It May Concern,

I have examined the individual named above and have reviewed their medical history and immunization records. Based on my evaluation, I am providing the following clearance information for the purpose of foster care placement or licensing.

1. Immunization Status:
[ ] The individual is up-to-date on all age-appropriate immunizations as recommended by the CDC and state guidelines.
[ ] The individual is currently on a catch-up schedule for the following vaccines: [List Vaccines].
[ ] The individual has a medical contraindication for the following vaccines: [List Vaccines].

2. Tuberculosis (TB) Screening:
[ ] TB Skin Test / IGRA Blood Test Date: [Date]
[ ] Result: [Negative / Positive]
[ ] (If positive) Chest X-ray Date: [Date] Result: [Clear/Negative]

3. Medical Clearance:
I find the individual to be in good physical and mental health. They are free from communicable diseases or chronic health conditions that would pose a risk to others or interfere with the care of a child. Any ongoing medical conditions are currently managed and stabilized.

4. Provider Comments:
[Insert any additional notes or restrictions here]

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

Sincerely,

[Signature of Physician/Healthcare Provider]

Provider Name: [Name and Title]
Medical Facility: [Clinic/Hospital Name]
License Number: [License #]
Phone: [Phone Number]