Date: [Insert Date]

To: [Insert Name of Adoption Agency/Social Worker]
Address: [Insert Agency Address]

RE: Medical Clearance for Adoption Placement
Patient Name: [Insert Full Name of Applicant]
Date of Birth: [Insert Date of Birth]

To Whom It May Concern,

I have conducted a comprehensive medical examination of [Insert Name of Applicant] on [Insert Date of Exam]. This evaluation was performed to determine the applicant's physical and mental fitness to undertake the responsibilities of adoptive parenthood.

Medical History:
I have reviewed the patient's medical history, including past illnesses, surgeries, and chronic conditions. At this time, the patient is being treated for: [Insert Conditions or "None"]. These conditions are currently [Insert Status, e.g., well-controlled].

Physical Examination:
The physical examination included a review of all major body systems. The patient's vital signs are within normal limits. There are no physical limitations that would interfere with the daily care, supervision, or safety of a child.

Mental and Emotional Health:
Based on my clinical observation and the patient's history, there is no evidence of untreated or unstable mental health disorders. The applicant appears emotionally stable and capable of managing the stresses associated with parenting.

Communicable Diseases:
The patient has been screened for communicable diseases as required. All relevant laboratory results (including Tuberculosis and HIV/Hepatitis, if requested) were found to be: [Insert Results, e.g., Negative/Non-reactive].

Physician's Statement:
In my professional opinion, [Insert Name of Applicant] is in good general health and has a normal life expectancy. I find no medical or psychological reasons why this individual should not be considered for adoption placement.

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

Sincerely,

[Physician Signature]

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