MEDICAL LETTER

Date:______________________________

POTENTIAL FOSTER PARENT NAME: _____________________________________

POTENTIAL FOSTER PARENT NAME:_____________________________________

The above referenced individuals meet the following criteria:

1. is considered free of communicable disease;
2. has no known physical or mental condition which would be hazardous to, or impact negatively a foster or adoptive child;
3. is considered able to accept responsibility for a foster or adoptive child without risking his or her own health;
4. is physically and mentally capable to be verified as a foster or adoptive parent; and

Physician Name: ____

Physician Address:_______________________________________

Telephone #:____

Physician Signature: _____________________________________

____ ____________________

THE CLIENT **DATE**

____ ____________________

THE CLIENT **DATE**