Date: [Insert Date]

To: [Recipient Name/Organization/School/Insurance]
From: [Physician Name]
Subject: Letter of Medical Necessity for Dietary Modifications

Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]
Diagnosis: Severe Food Allergy (ICD-10 Code: [Insert Code, e.g., T78.0])

To Whom It May Concern,

I am writing to formally document the medical necessity for specific dietary modifications for the patient listed above. This patient has been diagnosed with a life-threatening food allergy to the following allergen(s):

- [Insert Allergen, e.g., Peanuts]
- [Insert Allergen, e.g., Dairy]
- [Insert Allergen]

Exposure to even trace amounts of these allergens may result in anaphylaxis, a severe and potentially fatal systemic reaction. To manage this condition and ensure the safety of the patient, the following accommodations are medically required:

- Complete avoidance of the allergens listed above in all meals, snacks, and ingredients.
- Prevention of cross-contamination during food preparation and storage.
- [Optional: Provision of specialized medical formula or therapeutic foods.]
- [Optional: Access to an Epinephrine Auto-Injector at all times.]

These modifications are not a lifestyle choice but a medical requirement to prevent a life-threatening emergency. If you require further documentation or have questions regarding this patient's medical management, please contact my office.

Sincerely,

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