Date: [Insert Date]

To: [School Name] Administration and Food Service Department
From: [Physician Name/Medical Practice]
Subject: Medical Authorization for Dietary Accommodations

Student Name: [Insert Student Name]
Date of Birth: [Insert DOB]
Diagnosis: Celiac Disease

To Whom It May Concern,

The above-named student is under my care and has been diagnosed with Celiac Disease. This is a chronic autoimmune disorder where the ingestion of gluten causes damage to the small intestine. Strict life-long adherence to a gluten-free diet is the only treatment.

Required Accommodations:

- **Total Gluten Exclusion:** The student must not consume any foods containing wheat, barley, rye, or contaminated oats.
- **Cross-Contamination Prevention:** All meals prepared for the student must be made in a clean environment with dedicated or thoroughly cleaned utensils, surfaces, and cookware to avoid contact with gluten traces.
- **Ingredient Labeling:** Access to full ingredient lists for all school-provided meals and snacks.
- **Non-Food Activities:** The student must avoid gluten exposure in classroom activities (e.g., play-dough, pasta art, or flour-based science projects).

Symptoms of Accidental Exposure:
If gluten is accidentally ingested, the student may experience: [Insert symptoms, e.g., abdominal pain, vomiting, fatigue].

These accommodations are medically necessary to ensure the student's health and safety while at school. Please include this information in the student's 504 Plan or Individualized Health Plan (IHP).

If you have any questions regarding these requirements, please contact my office at [Insert Phone Number].

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Medical License Number]
[Clinic/Hospital Stamp]