

Date: [Insert Date]

To: [Name of Institution/School/Organization]
From: [Name of Physician/Medical Provider]
Subject: Medical Exemption for Dietary Requirements

To Whom It May Concern,

I am the treating physician for [Patient Name], born on [Date of Birth]. [Patient Name] is currently under my care for a chronic gastrointestinal condition that necessitates strict dietary management.

Due to the specific nature of this medical condition, the patient requires a highly specialized diet that cannot be consistently or safely met by standard cafeteria food services. Consumption of restricted ingredients or cross-contaminated food items poses a significant risk to the patient's health and may lead to severe gastrointestinal distress or medical complications.

Therefore, I am requesting a formal medical exemption for [Patient Name] from the mandatory cafeteria meal plan. This exemption is necessary to allow the patient to provide and consume their own medically supervised meals.

Specific dietary restrictions include, but are not limited to:

- [Insert specific restriction, e.g., Gluten-free]
- [Insert specific restriction, e.g., Low FODMAP]
- [Insert specific restriction, e.g., Severe Dairy Allergy]

This medical recommendation is effective as of [Start Date] and is expected to remain in place until [End Date or "Indefinitely"].

Should you require any further documentation or have questions regarding this medical necessity, please contact my office at [Phone Number].

Sincerely,

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