[Physician Name/Clinic Name]
[Address]
[City, State, Zip Code]
[Phone Number]

Date: [Date]

To: [School Name/School Administration]

Re: [Student Name]
Date of Birth: [Student DOB]

To Whom It May Concern,

[Student Name] is currently under my medical care for the treatment of [Celiac Disease / Non-Celiac Gluten Sensitivity / Wheat Allergy]. To manage this condition and prevent serious health complications, the student must strictly adhere to a lifelong gluten-free diet.

I am requesting the following dietary accommodations for the [Year] school year:

- **Strict Gluten-Free Diet:** Total avoidance of all foods containing wheat, barley, rye, and cross-contaminated oats.
- **Cross-Contamination Prevention:** Food must be prepared in a clean environment using separate utensils, cutting boards, and cookware to avoid contact with gluten containing crumbs or residues.
- **Safe Snack/Meal Storage:** Permission for the student to store safe, labeled snacks or meals in a designated area.
- **Non-Food Activities:** Use of gluten-free materials in the classroom (e.g., avoiding play-dough, wheat-based pastes, or certain art supplies containing gluten).
- **Hand Washing:** Encouraging hand washing for peers after eating gluten-containing foods to prevent transfer to shared surfaces.

In the event of accidental gluten ingestion, the student may experience symptoms including, but not limited to: [list symptoms, e.g., abdominal pain, vomiting, fatigue]. Please allow the student unrestricted access to the restroom and the school nurse if an exposure is suspected.

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

Sincerely,

[Physician Signature]

[Physician Name, Title]
[Medical License Number]