Date: [Insert Date]

To: School Administration, School Nurse, and Food Service Staff
School Name: [Insert School Name]
Student Name: [Insert Student Name]
Date of Birth: [Insert DOB]

To Whom It May Concern,

[Student Name] is currently under my care for the treatment of [Insert Diagnosis, e.g., Refractory Epilepsy]. As a critical part of their medical treatment, this student has been prescribed a strict **Medical Ketogenic Diet**. This diet is a calculated medical therapy, not a lifestyle preference, and requires precise adherence to prevent serious medical complications or breakthrough seizures.

To ensure the safety and health of the student while at school, the following accommodations are required:

- **Strict Dietary Intake:** The student must only consume foods and liquids provided by their parents/guardians or specifically approved by their medical team. No outside snacks, "treats," or shared classroom food are permitted.
- **Supervision During Meals:** A staff member should monitor the student during lunch and snack times to ensure they do not trade food or consume items not intended for them.
- **Non-Food Rewards:** Please use stickers, pencils, or extra recess instead of food-based rewards for classroom achievements.
- **Hydration:** The student must have unrestricted access to water throughout the school day.
- **Ingredient Restrictions:** Many non-food items contain hidden carbohydrates (sugars/starches) that can be absorbed through the skin or accidentally ingested. Please use carbohydrate-free versions of:
    - Toothpaste and mouthwash
    - Art supplies (e.g., playdough, certain glues, and finger paints)
    - Hand sanitizers and lotions (where possible)
- **Emergency Protocol:** If the student experiences a seizure, or displays symptoms of hypoglycemia (lethargy, dizziness, confusion) or illness (vomiting), please contact the parents and school nurse immediately.

I have attached a specific Ketogenic Meal Plan and an Emergency Action Plan for your records. If you have any questions regarding these medical requirements, please contact my office at [Insert Phone Number].

Sincerely,

[Physician Signature]
Physician Name: [Insert Name]
Clinic/Hospital: [Insert Facility Name]
Phone: [Insert Phone Number]