Date: [Insert Date]

Patient Name: [Insert Patient Full Name]
Date of Birth: [Insert Date of Birth]
Patient ID/Reference: [Insert ID Number]

To Whom It May Concern,

I am writing to formally provide medical clearance and dietary requirements for the above-named patient, who is currently under my care. Based on clinical diagnosis and medical history, it is medically necessary for the patient to adhere to the following dietary restrictions:

Diagnosed Condition(s):
[e.g., Celiac Disease, Severe Nut Allergy, Lactose Intolerance]

Foods/Ingredients to Avoid:
[List specific allergens or food groups here]

Required Dietary Substitutions:
[List safe alternatives or specific meal requirements]

Severity of Reaction:
[e.g., Life-threatening Anaphylaxis, Digestive Distress, Inflammatory Response]

Please ensure that all meals provided to this individual are prepared in a manner that prevents cross-contamination with the excluded items listed above.

If you require further clarification or additional medical documentation, please contact my office at [Insert Phone Number].

Sincerely,

[Signature of Medical Professional]
Name: [Insert Physician Name]
Title: [Insert Medical Title/Specialty]
Medical License Number: [Insert License Number]
Facility Name: [Insert Clinic/Hospital Name]