LÆGEERKLÆRING · MEDICAL CERTIFICATE

# Cøliaki - glutenfri kost af medicinske grunde

*Coeliac disease - medically required gluten-free diet*

**LÆGENS / KLINIKKENS NAVN, ADRESSE OG KONTAKT — PHYSICIAN / CLINIC LETTERHEAD**

(Udfyldes af lægen, eller brug klinikkens brevpapir / To be completed by the physician, or use clinic letterhead)

**PATIENT — NAVN / NAME** _____

**FØDSELSDATO / DATE OF BIRTH** _____

## DANSK

Til rette vedkommende,

Ovennævnte patient har **cøliaki** - en kronisk, autoimmun sygdom, der kræver en **streng, livslang glutenfri kost**. Selv små mængder gluten skader tarmen. Patienten skal undgå al gluten (hvede, rug, byg og produkter heraf).

Af medicinske grunde medbringer patienten egne glutenfri fødevarer, når sikker mad ikke kan garanteres undervejs. Jeg anmoder venligst om, at patienten tillades at **medbringe disse fødevarer** (herunder gennem sikkerhedskontrol og told) og imødekommes med hensyn til kosten under rejse og ophold.

Med venlig hilsen,

## ENGLISH

To whom it may concern,

The above patient has **coeliac disease** - a chronic, autoimmune condition requiring a **strict, lifelong gluten-free diet**. Even small amounts of gluten damage the intestine. The patient must avoid all gluten (wheat, rye, barley and products thereof).

For medical reasons, the patient carries their own gluten-free food when safe food cannot be guaranteed. I kindly request that the patient be permitted to **bring these food items** (including through security and customs) and be accommodated regarding their diet during travel and their stay.

Yours faithfully,

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**LÆGE / PHYSICIAN (NAVN)** _____

**DATO / DATE** _____

**UNDERSKRIFT OG STEMPEL / SIGNATURE AND STAMP**

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*Denne skabelon udfyldes og underskrives af patientens egen læge. Uden lægens underskrift og stempel er den ikke en gyldig erklæring. — This template is to be completed and signed by the patient's own physician; it is not valid without the physician's signature and stamp.*