PRESCRIPTION

``` Dr. [Your Name] [Your Clinic Name] [Your Clinic Address] [License No.][Your License Number] [Contact Number] Patient: [Patient's Name] Age: [Patient's Age] Gender: [Patient's Gender] Date: [Date of Prescription] Address: [Patient's Address] --- Rx: 1. **Dimenhydrinate** Quantity: 20 tablets Sig: Take 1 tablet every 4 to 6 hours as needed for dizziness. Do not exceed 300 mg in 24 hours. Take with food if stomach upset occurs. 2. **Meclizine** Quantity: 10 tablets Sig: Take 1 tablet 1 hour before travel or as directed. May cause drowsiness. Avoid driving or operating machinery until you know how it affects you. --- Monitoring: Schedule follow-up in 2 weeks to assess symptom management and medication effectiveness. ```
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