

PRESCRIPTION

`` **PRESCRIPTION** **Date:** [Insert date] **Patient Information:** - Name: [Insert patient's name] - Age: [Insert patient's age] - Gender: [Insert patient's gender] **Medication Prescribed:** 1. **Paracetamol** 500 mg **Quantity:** 20 tablets **Sig:** Take 1 tablet orally every 4 to 6 hours as needed for pain. Do not exceed 4 grams in 24 hours. 2. **Oral Rehydration Solution (ORS)** **Quantity:** 5 packets **Sig:** Dissolve 1 packet in 1 liter of water. Drink 200-400 mL after each loose stool or as needed for hydration. 3. **Antacids (e.g., Magnesium Hydroxide and Aluminum Hydroxide)** **Quantity:** 30 tablets **Sig:** Take 1-2 tablets 1 hour after meals and at bedtime. 4. **Prokinetic (e.g., Metoclopramide)** **Quantity:** 10 tablets **Sig:** Take 1 tablet orally 30 minutes before meals as needed for gastric discomfort. **Prescriber Information:** - Name of Prescriber: [Insert prescriber's name] - License No.: [Insert license number] ``