

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. ``