# Pediatric Medication Prescription Document

Date: _____

## Patient Information

**Full Name:** _____ **DOB:** _____

**Gender:** _____ **Weight:** _____ kg

**Parent/Guardian:** _____

**Contact Number:** _____ **Address:** _____

## Prescription Details

| Medication Name | Dose | Route | Frequency | Duration | Instructions |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

## Additional Notes

_____

Prescribing Physician Signature

Parent/Guardian Signature