

Pediatric Outpatient Prescription

Patient Name:

Date of Birth:

Age:

Sex:

Patient ID:

Date:

Weight (kg):

Diagnosis:

Prescription

Medicine Name	Dosage	Frequency	Route	Duration	Instructions

Allergies:

Special Instructions:

Doctor's Name & Signature

Parent/Guardian Signature

Note: Please follow up as advised by your doctor. Store this prescription safely and bring it for future visits.