Dr. Rumana Qazi, MD Dr. Shirley Ulep, MD
Dr. Valerie Sia, MD Dr. Mariane Ibrahim, MD
Dr. Reza Razvi, DO

Permission to Medicate

Patient Name: _____

Patient DOB: _____

To Whom It May Concern,

Name of Medication: _____

Dosage and time to be taken: _____

Length of time medication will be required: _____

Any known medication allergies: _____

Signature of parent/guardian: _____

Signature of physician: _____

_____
Office Stamp

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