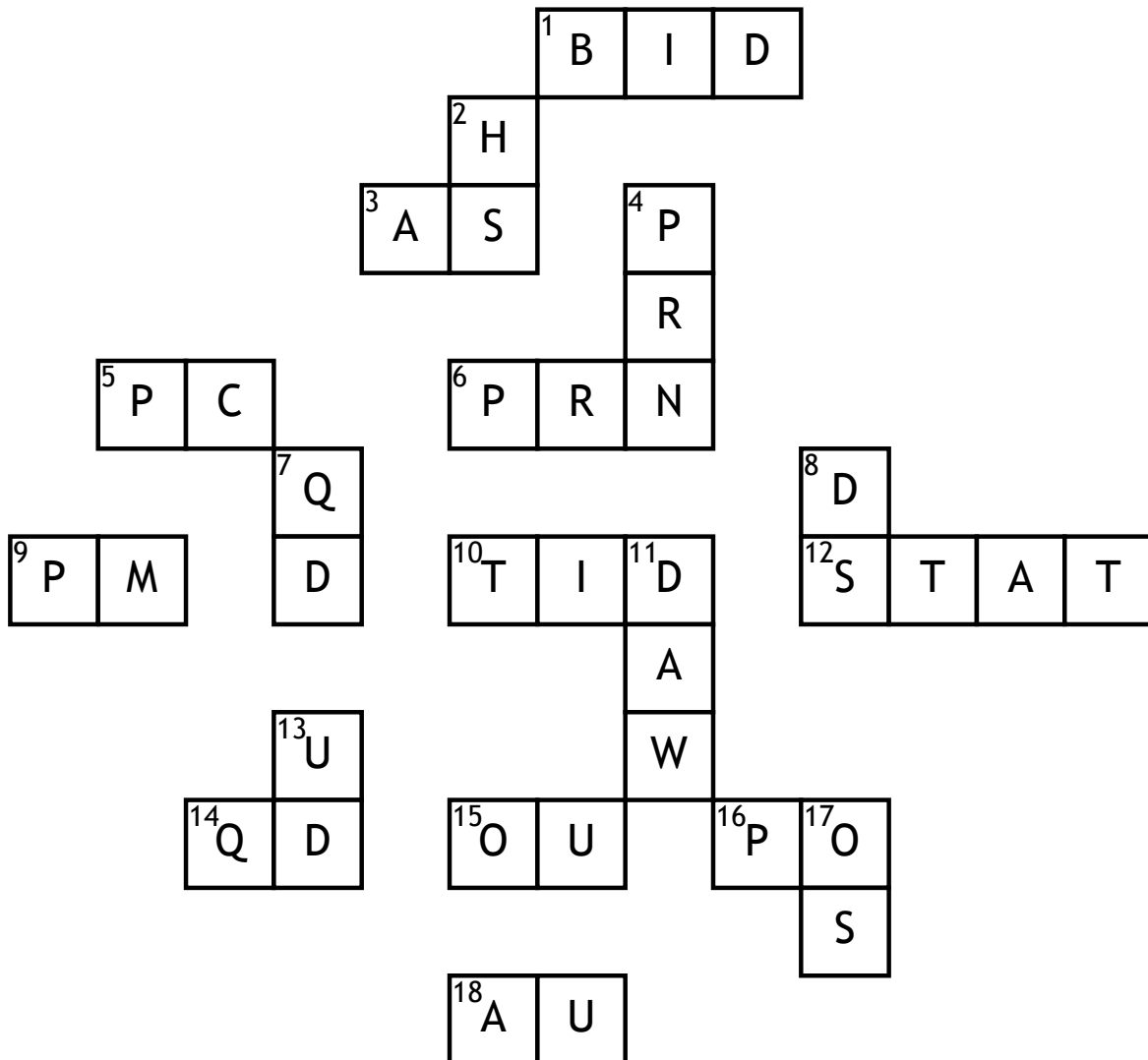


Name: \_\_\_\_\_

Date: \_\_\_\_\_

# SIG Codes



## Across

- 1. twice daily
- 3. left ear
- 5. after meals
- 6. as needed
- 9. afternoon
- 10. three times daily

- 12. immediately

- 14. daily
- 15. both eyes
- 16. by mouth
- 18. both ears

## Down

- 2. at bedtime

- 4. as soon as possible

- 7. every day

- 8. double strength

- 11. dispense as written

- 13. as directed

- 17. left eye