



PRESCRIPTION AUTHORISATION

Date: _____

Patients Details:

First Name: _____ Last Name: _____

Phone No: _____

Date of Birth: ____ / ____ / ____

Presenting Problem:

Current Medications:

Allergies:

Student Practitioner Details

Student Practitioner's Name: _____

Student Practitioner's Signature: _____ 

Student Phone No: _____

CLINIC SUPERVISOR DETAILS

Supervisor / Lecturer's Name: _____

Supervisor / Lecturer's Signature: _____ 

Supervisor / Lecturer's Phone No: _____

NB: Incomplete prescriptions and forms without a legible supervisor's name and signature will NOT be made up. The Information contained herein will remain confidential.

Only Prescriptions signed by a Nature Care Supervisor or Lecturer will be accepted.



Nature Care College

PRESCRIPTION AUTHORISATION

PRESCRIPTION:

(for herbal formulas state botanical name and amount of each ingredient)

Dose:

Bottle size: _____ *mls*