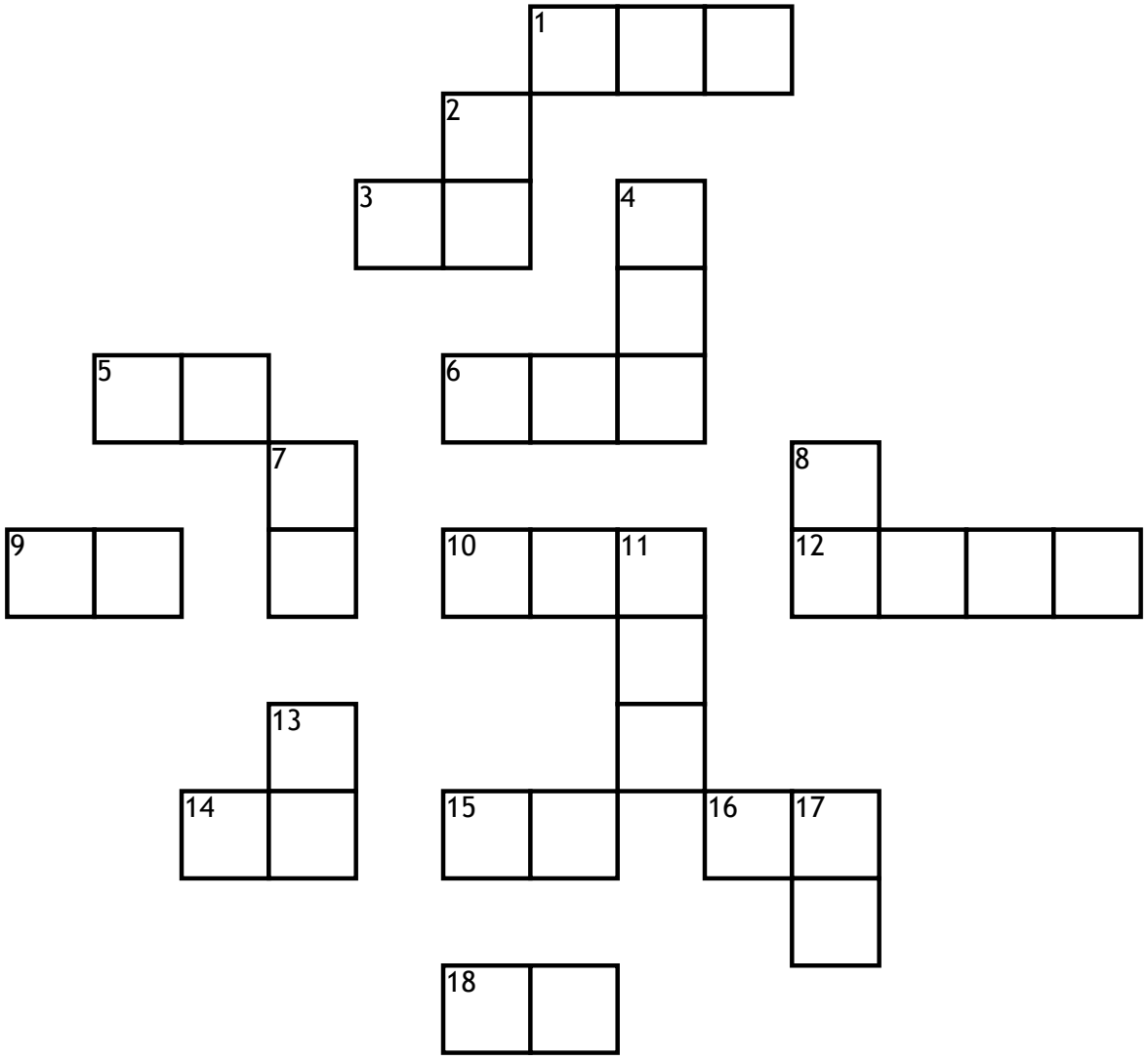
Name: _____ Date: _____

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