**Medication Administration Record – SELF-CARE: Dry Skin**

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| --- | --- | --- |
| Name:  | D.O.B:  | Allergies: |
| Address:  |
|
| Doctor:  | Start Date:  | End Date: | Start Day:  |

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| --- | --- | --- | --- | --- | --- |
|  |  | Week 1 | Week 2 | Week 3 | Week 4 |
| Medication Profile | Date:Time/Dose: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Name on package:…………………………………….Directions on package:……………………………………. | 08:00 |  |  |  |  |  |  |  |  |  |  |  |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 12:00 |  |  |  |  |  |  |  |  |  |  |  |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 16:00 |  |  |  |  |  |  |  |  |  |  |  |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 20:00 |  |  |  |  |  |  |  |  |  |  |  |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
|   |  |  |  |  |  |  |  |  |  |  |  |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
|   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| Carried forward:  | Qty recd:  | by:  | date:  | Returned:destroyed:   | Qty: | By: |

**Key: R=Refused, N=Nausea or Vomiting, H=Hospital, L= On leave, D=Destroyed, S=Sleep, M=Made available, O=Other**

For example: E45 cream, Aquamax, Diprobase, Zerobase, Cetraben, Hydromol, Epimax……(*this list is not exhaustive*)

**I have read and understood the information in the product Patient Information Leaflet** **(tick)**