**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 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 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)**