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| **Name:** | **Month: Year:** |

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| **Medication/ dosage/ frequency/route** | **Time** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **11** | **12** | **13** | **14** | **15** | **16** | **17** | **18** | **19** | **20** | **21** | **22** | **23** | **24** | **25** | **26** | **27** | **28** | **29** | **30** | **31** |
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| **Initial** | **Signature** | **Known allergies or adverse reactions:** |
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| **Date/Time** | **Medication/Dosage** | **Reason** | **Results** | **Hour/Initials** |
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**Vital signs or other tracking per physician or team request:**

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|  | **Date:** | **Date:** | **Date:** | **Date:** | **Date:** | **Date:** |
| **Weight** |  |  |  |  |  |  |
| **Blood Pressure** |  |  |  |  |  |  |
| **Temperature** |  |  |  |  |  |  |
| **Pulse** |  |  |  |  |  |  |
| **Other:** |  |  |  |  |  |  |