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Client Initials: \_\_\_\_\_

Month/Year: \_\_\_\_\_

**Please note if no changes have occurred or give details on changes made. Fill out EVERY week.**

Medications:

Dosage/Times Administered:

What is the purpose:

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Date: \_\_\_\_\_

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Date: \_\_\_\_\_

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Date: \_\_\_\_\_

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Date: \_\_\_\_\_

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Date: \_\_\_\_\_

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