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| ***Date***  |  |
| ***Base***  |  |
| ***Host Name*** |  |



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| *Case number* | *Medication**PLEASE PRINT*  | *Strength* | *Amount (e.g. 1 box)* | *Tablet* | *Suspension*  | *Injection*  | *Have you checked if a pharmacy is open?* | *Time medication issued* | *Clinician Name**PLEASE PRINT* |
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***Form to be completed by the Clinician when dispensing medication from stock supplies, please return this form to the black post box at the end of the shift.***