**ANNEXE 11**

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| **REGISTRE DES AIDES-SOIGNANTS AUTORISÉS À ADMINISTRER DES MÉDICAMENTS** |
| **Nom du lieu (RPA, ressource, installation ou autre) : Nom du responsable du lieu :** |
|  | **VOIE D’ADMINISTRATION DES MÉDICAMENTS** |
| **INSCRIRE LA DATE D’AUTORISATION (A) ET LES INITIALES (I) DU RESPONSABLE DU LIEU POUR CHAQUE VOIE D’ADMINISTRATION** |
| **Nom de l’aide-soignant** | Orale | Topique | Transdermique | Ophtalmique | Auriculaire | Nasale | Rectale | Entérale | Vaginale | Inhalation | Insuline SC |
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| **REGISTRE DES AIDES-SOIGNANTS AUTORISÉS À ADMINISTRER DES MÉDICAMENTS** |
| **Nom du lieu (RPA, ressource, autre) : Nom du responsable du lieu :** |
| **VOIE D’ADMINISTRATION DES MÉDICAMENTS** |
| **INSCRIRE LA DATE D’AUTORISATION (A) ET LES INITIALES (I) DU RESPONSABLE DU RESPONSABLE QUI COMPLÈTE LE FORMULAIRE** |
| **Nom de l’aide-soignant** | Orale | Topique | Transdermique | Ophtalmique | Auriculaire | Nasale | Rectale | Entérale | Vaginale | Inhalation | Insuline SC |
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| **SIGNATURE** | **INITIALES** | **SIGNATURE** | **INITIALES** | **SIGNATURE** | **INITIALES** | **SIGNATURE** | **INITIALES** |
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