**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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