

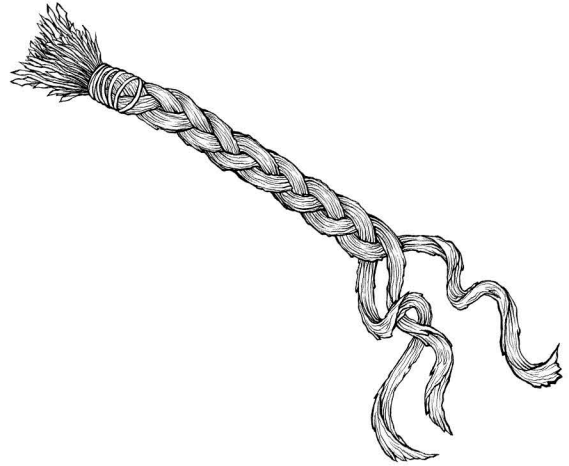
Name: _____

Date: _____

NAME THE MEDICINE



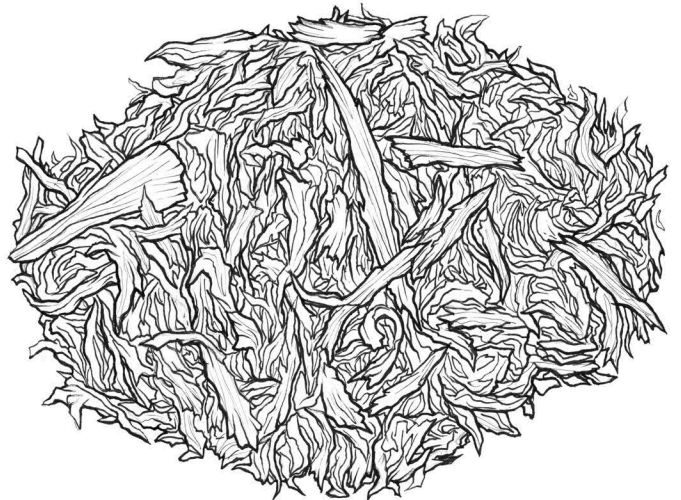
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