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| **DEPENDENCIA:** | **ASUNTO:** |
| **FECHA:**  | **LUGAR:**  |

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| Nombres y apellidos | Documento | Edad | Hora | Consulta médica en Centro Día | Asesoría Psicosocial | Nombre Taller y/o Capacitación | Alimentación | Firma |
| Si | No | Si | No | Desayuno | Almuerzo | Refrigerio |
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