



Japanese Children's Society, Inc.

8 West Bayview Ave., Englewood Cliffs, NJ 07632

保護者各位

学園におけるお子様への薬剤投与に関して

学園あるいは校外学習等において、スクールナース、または学園スタッフ、あるいはお子様自身による、お子様への薬剤の投与が必要な場合は、添付の用紙に担当医及び保護者に必要事項を記載頂き、学園までご提出ください。また、担当医には薬剤の投与方法等も詳細に記載して頂きます様お願い致します。薬剤の名称、投与量や投与方法などを用紙にご記入の上、その用紙と薬剤を、入れ物や袋等（薬剤名を英語表記する）に入れて学園にお持ちください。学園で保管いたします。使用期限が切れた場合には、新しいものをお持ちください。各薬剤につき、それぞれの用紙が必要となります。これらの書類の提出がない場合は、薬剤は与えることが出来ませんので、ご承知おきください。

また、喘息、アレルギー等の重篤な発作などが引き起こされた場合、命に関わる可能性がある症状をお持ちでいらっしゃるお子様や、熱性痙攣等の既往歴をお持ちのお子様に関しては、別途書類をお渡しさせて頂きますので学園事務局までお知らせ下さい。

ご質問等ございましたらスキー担当（201-676-0010／ski@nyikuei.org）までお問い合わせください。

投与許可書が必要な薬剤：処方箋の必要な薬剤、一般用医薬品、すべての点眼薬

投与許可書が必要でない薬剤：日焼け止め、虫除けスプレー、保湿ローションなど

※投与許可書が必要でない薬剤の投与に関してはお子様をご自分で使用できる場合はご自分で使用して頂いてかまいません。小さなお子様の場合は、学園スタッフが対応いたします。

Dear Parents,

The state of New Jersey requires us to have written permission from you and your physician in order for us or your child to give any medication to your child while in school or on school trips. If it is necessary for your child to receive any medication in school and /or on school trips, please ask your physician for written directions and have him complete the enclosed form. All medication should be in the labeled container. This container will remain in school. We also require a written note from the parent/guardian giving permission to administrator the medication. Necessary forms are enclosed for your convenience. Each medication has to have each form.

If your child has any allergy, asthma or another potentially life –threatening illness, you are required to submit a different form for us to administrator the medication. If it is the case, please inform school administrator.

Thank you,
Japanese Children's Society School Nurse

October 1, 2026

保護者記入箇所

1. Name/type of medication _____	
2. Is the prescribed medication _____	
3. Dosage/amount to be _____	
4. Route of administration _____	
5. Frequency and time of _____	
6. Duration (week, month) _____	
7. Diagnosis, intended effect _____	on (symptoms, side effects, etc.) _____
8. Other medication studies _____	
9. Other requirements or _____	
10. Must this medication _____	in order to allow the student to attend _____
11. Is supervised student _____	
12. For Asthma Medication _____	unsupervised self-administration _____
authorized? _____	

Part I はドクターによって記入いただきます。

Telephone No.

PartII 保護者記入箇所

I hereby request and grant permission for Japanese Children's Society school personnel to [check one]
 _____ administer or _____ permit the self-administration of medication to/by my daughter/son according
 to the above _____ conditions. I understand that administration by school personnel may be performed by an
 independent _____ indicated and registered school nurse, and I specifically consent to this. I
 further waive any claims against the School District, members of the Board of Education, its employees,
 and agents arising out of the administration or self administration of said medication, and agree to hold
 harmless and indemnify the School District, the members of the Board of Education, its employees and
 agents, either jointly or severally, from and against any and all liability, claims, demands, damages, or
 causes of action or injuries, costs, and expenses, including attorneys' fees, resulting from or arising out
 of the administration or self administration of medication. With respect to student self-administration of
 asthma medication and auto-injectors, this waiver and indemnification are not applicable to
 willful and wanton acts or omissions required by law. For Asthma Medication/Epinephrine Auto-Injectors
 Only: I consent to my child's possession and self-administration of asthma medication/ Epinephrine
 Auto-Injectors: yes no.

Date (日付)

October 1, 2026

Japanese Children's Society
Medication Administration/Self Administration Consent Form

School Grade _____
Name of Student _____
Date of Birth _____
Address _____
Emergency Phone _____

Part I - Physician's Statement (This statement may be signed by a physician's assistant or advance practice registered nurse having such authority delegated by a supervising/collaborating physician.)

1. Name/type of medication _____
2. Is the prescribed medication for an asthmatic condition? _____
3. Dosage/amount to be given _____
4. Route of administration _____
5. Frequency and time of administration _____
6. Duration (week, month, indefinite, etc.) _____
7. Diagnosis, intended effect and anticipated reaction to medication (symptoms, side effects, etc.) _____
8. Other medication student is receiving _____
9. Other requirements or special circumstances _____
10. Must this medication be administered during the school day in order to allow the student to attend school? _____
11. Is supervised student self-administration authorized? _____
12. For Asthma Medication/Epinephrine Auto-Injectors Only*: Is unsupervised self-administration authorized? _____

*Upon parental consent, a student who is prescribed asthma medication and/or an epinephrine auto-injector may possess and use his/her asthma medication and/or epinephrine auto-injector during school or at school-sponsored activities without the supervision of District personnel.

Physician's Signature

Date Signed

Address

Telephone No.

Part II - Parent's Request/Approval

I hereby request and grant permission for Japanese Children's Society school personnel to [check one] _____ administer or _____ permit the self-administration of medication to/by my daughter/son according to the above instructions. I understand that administration by school personnel may be performed by an individual other than a certificated and registered school nurse, and I specifically consent to this. I further waive any claims against the School District, members of the Board of Education, its employees, and agents arising out of the administration or self administration of said medication, and agree to hold harmless and indemnify the School District, the members of the Board of Education, its employees and agents, either jointly or severally, from and against any and all liability, claims, demands, damages, or causes of action or injuries, costs, and expenses, including attorneys' fees, resulting from or arising out of the administration or self administration of medication. With respect to student self-administration of asthma medication and epinephrine auto-injectors, this waiver and indemnification are not applicable to willful and wanton acts to the extent required by law. For Asthma Medication/Epinephrine Auto-Injectors Only: I consent to my child's possession and self-administration of asthma medication Epinephrine Auto-Injectors: _____ yes _____ no.

Signed _____

Phone # _____

Date _____

October 1, 2026