



# Marist Brothers International School

## Medication Authorization Form

Students requiring medication during school hours should have the medication administered by the School Nurse. Please fill out the following information to request administration by the School Nurse and return the form to the Health Office. If medication is to be taken on a daily basis, or for 5 consecutive school days or more, please consult directly with the School Nurse. Also, please note that it is the student's responsibility to come to the Health Office at the scheduled time for the School Nurse will not administer medication in the classroom.

Student Name : \_\_\_\_\_

Grade : \_\_\_\_\_ Date of Birth : \_\_\_\_\_

Known allergies : \_\_\_\_\_

I hereby request the School Nurse to administer to my child the medication(s) listed below during school hour at the time indicated. I understand and accept that neither the School nor the School Nurse may be held responsible for any effects caused by the medication administered. I also understand that any prescribed medication to be administered must be authorized in writing by a physician and that any non-prescribed medication to be administered for more than 3 consecutive days must also be authorized in writing by a physician.

\_\_\_\_\_

Parent Signature Date

|   | <b>1</b> | <b>2</b> | <b>3</b> | <b>4</b> |
|---|----------|----------|----------|----------|
| Name of medication  |          |          |          |          |
| Reason for taking   |          |          |          |          |
| Date(s) given   |          |          |          |          |
| Time given  |          |          |          |          |
| Route   |          |          |          |          |
| Dose (tablets, packs, cc, ml, etc.)   |          |          |          |          |
| Directions<br>Use patient friendly directions.<br>Do not use medical abbreviations. |          |          |          |          |
| Other information   |          |          |          |          |
| Nurse's note:   |          |          |          |          |

Your child has received the medication(s), indicated above, as directed.

\_\_\_\_\_

School Nurse Signature Date



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## 学校での投薬に関する承諾書

学校でお薬の投与が必要なお子様は、スクールナースが投与を行いません。正確に投与を行なう為に、下記の項目を記入し、ヘルスオフィスまでご提出下さい。日常的、又は5日以上継続してお薬の投与が必要なお子様は、お手数ですがスクールナースまでご相談下さい。また、教室での投薬は行いませんので、お子様が責任を持って、時間どおりにヘルスオフィスに来られるよう、ご理解とご協力をお願い致します。

生徒氏名（アルファベット記入）： \_\_\_\_\_

学年： \_\_\_\_\_ 生年月日： \_\_\_\_\_

アレルギーの有無： \_\_\_\_\_

下記の通り、スクールナースにお薬の投与をお願いします。万が一、投与した薬が副作用を引き起こした場合は、学校及びスクールナースは責任を負いかねる事を承知いたします。医師に処方されたお薬を投与する場合、又は市販薬を3日以上継続で投与する場合は、必ず医師・薬剤師からの説明書・許可書を提出します。

保護者署名

日付

|                                   | 1 | 2 | 3 | 4 |
|-----------------------------------|---|---|---|---|
| 薬品名                               |   |   |   |   |
| 服用理由                              |   |   |   |   |
| 投薬日                               |   |   |   |   |
| 服用時刻                              |   |   |   |   |
| 服用法                               |   |   |   |   |
| 服用量（錠、袋、cc、ml）                    |   |   |   |   |
| 服用指示<br>医療用語を避け、わかりやすい表現でご記入ください。 |   |   |   |   |
| その他の注意事項                          |   |   |   |   |
| ナース記入欄：                           |   |   |   |   |

上記の指示通り、お子様に薬を投与しました。

スクールナース署名

日付