



# Harbor Country Day School

## 2025-2026 Yearly Health Survey & Emergency Contacts

Student Name \_\_\_\_\_ Grade \_\_\_\_\_

Date of Birth \_\_\_\_\_

Home Address \_\_\_\_\_

Home Phone# \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_

Parent/Guardian Business Address \_\_\_\_\_

Parent/Guardian Day Phone# \_\_\_\_\_ Cell Phone# \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_

Parent/Guardian Business Address \_\_\_\_\_

Parent/Guardian Day Phone# \_\_\_\_\_ Cell Phone# \_\_\_\_\_

Parent/Guardian email address \_\_\_\_\_

Emergency Contact 1 \_\_\_\_\_

Contact 1 Phone# \_\_\_\_\_ Alternate# \_\_\_\_\_

Relationship \_\_\_\_\_ Can pick up? \_\_\_\_\_

### Emergency Contacts (other than parents)

Emergency Contact 2 \_\_\_\_\_

Contact 2 Phone# \_\_\_\_\_ Alternate# \_\_\_\_\_

Relationship \_\_\_\_\_ Can pick up? \_\_\_\_\_

Emergency Contact 3 \_\_\_\_\_

Contact 3 Phone# \_\_\_\_\_ Alternate# \_\_\_\_\_

Relationship \_\_\_\_\_ Can pick up? \_\_\_\_\_

Doctor Name \_\_\_\_\_ Phone# \_\_\_\_\_

Dentist Name \_\_\_\_\_ Phone# \_\_\_\_\_

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**17 Three Sisters Road | Saint James, New York 11780**

**(631) 584-5555 | [www.hcdsny.org](http://www.hcdsny.org)**



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## Yearly Health Survey (2025-2026)

1. Has your child had any illness or operations in the past year?  
Yes/No (Circle One)  
Explain:\_\_\_\_\_
  
2. Is there anything concerning the general health of your child that would aid the school in a better understanding of him/her?  
\_\_\_\_\_  
\_\_\_\_\_
  
3. Does your child take any medications at home?  
Name of Medication\_\_\_\_\_Frequency\_\_\_\_\_
  
4. Does your child wear glasses/contacts?  
a. Yes/No Re-exam date:\_\_\_\_\_
  
5. Does your child have a hearing problem?  
a. Yes/No Explain:\_\_\_\_\_
  
6. Other concerns:\_\_\_\_\_
  
7. Does your child have any allergies? Yes/No  
Please specify cause, symptoms, and treatment:  
\_\_\_\_\_
  
8. Does your child have Asthma? Yes/No  
Please specify cause and treatment:  
\_\_\_\_\_

Parent/Guardian Signature:\_\_\_\_\_Date:\_\_\_\_\_