



Harbor Country Day School

2026-2027 Yearly Health Survey & Emergency Contacts (Preschool 2s, 3s, 4s)

Student Name_____ Grade_____

Date of Birth_____ Student Nickname_____

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_____

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Emergency Contacts (other than parents)

Emergency Contact 1_____

Contact 1 Phone#_____ Alternate#_____

Relationship_____ Can pick up?_____

Emergency Contact 2_____

Contact 2 Phone#_____ Alternate#_____

Relationship_____ Can pick up?_____

Emergency Contact 3_____

Contact 3 Phone#_____ Alternate#_____

Relationship_____ Can pick up?_____

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Doctor Name_____ Phone#_____

Dentist Name_____ Phone#_____

17 Three Sisters Road | Saint James, New York 11780

(631) 584-5555 | www.hcdsny.org



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Yearly Health Survey (2026-2027)

1. Has your child had any illness or operations in the past year?
Yes/No (Circle One)
Explain: _____

 2. Does your child take any medications at home?
Name of Medication _____ Frequency _____
 3. Does your child wear glasses?
a. Yes/No Re-exam date: _____
 4. Does your child have reoccurring ear infections?
 5. Has your child been previously evaluated or has your pediatrician suggested an evaluation for issues such as speech, motor abilities, food aversions, allergies, vision or hearing?
 6. Does your child have a sensitivity to loud noises?
 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:

 9. Is there anything concerning the general health of your child that would aid the school in a better understanding of him/her?

- Parent/Guardian Signature: _____ Date: _____

The above information will be shared with all faculty and staff responsible for the health and safety of your child.

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