



Harbor Country Day School

2026-2027 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



Yearly Health Survey (2026-2027)

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:_____