Harbor Country Day School

Yearly Health Survey/ Emergency Contacts
Health Office 2019-2020

Student Name________________________________ **Grade**____________
Date of Birth___________________________
Home Address____
Home Phone#____

Father's Name____
Father's Business Address____
Father's Day Phone#________________**Father's Cell Phone#**____________

Mother's Name____
Mother's Business Address____
Mother's Day Phone#________________**Mother's Cell Phone#**___________

Parent email address____

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?**_____________________

Doctor Name_______________________**Phone#**_______________________
Dentist Name_______________________**Phone#**_______________________

Harbor Country Day School

Yearly Health Survey
2019-2020

1. **Has your child had any illness or operations in the past year?**
   Yes/No

Explain____

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

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3. **Does your child take any medications at home?**

Name of Medication__________________________**Frequency**____________

4. **Does your child wear glasses? Yes/No Re-exam date**_____________

Does your child wear contacts? Yes/No Re-exam date _______________

5. **Does your child have a hearing problem?** ________________________

6. **Other concerns**____

7. **Does your child have any allergies? Yes/No**

Please specify cause, symptoms, and treatment:___________________________

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8. **Does your child have Asthma? Yes/No**

Please specify cause and treatment: ____________________________________

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

Parent Signature________________________________**Date**____________