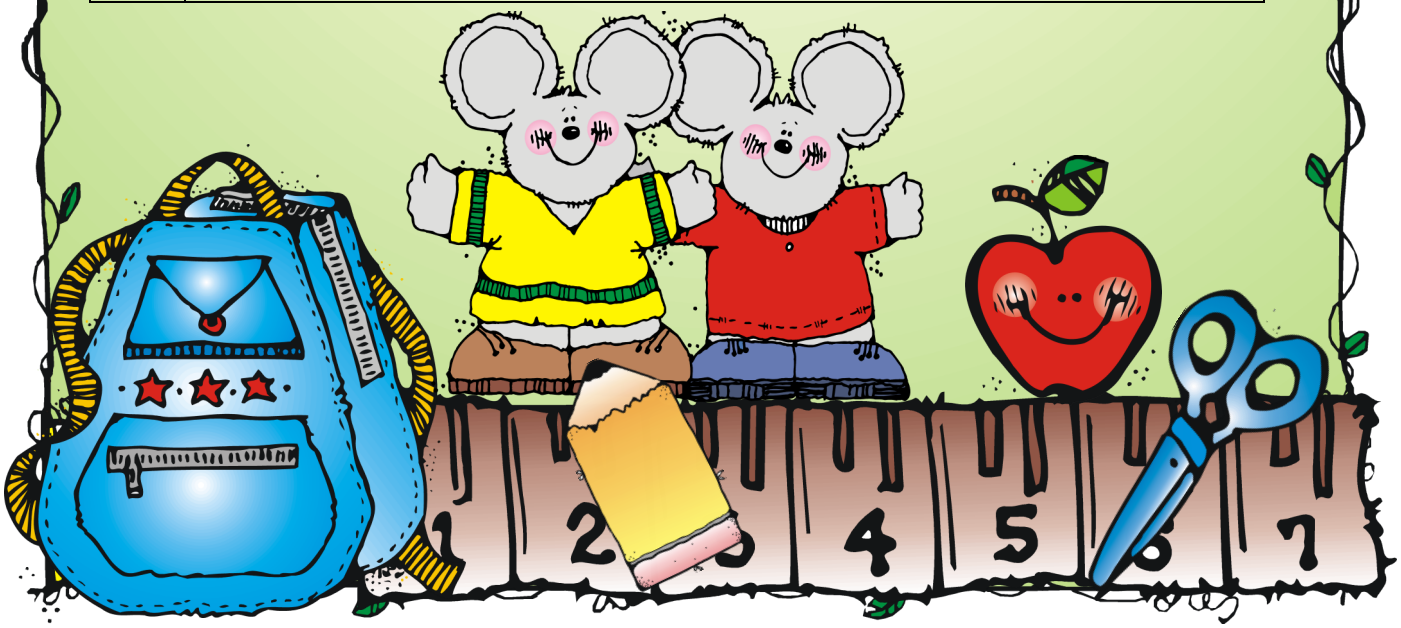
Welcome to St. Peter's School

Attached is our 6 page application.
Checklist to complete:

	1. Type in pages 2 thru 6 Note: Complete all fields
	2. Download to print
	3. Parent/Guardian signature required on pages 2 thru 6
	4. The Health Form (page 7) must be completed by your child's physician
	5. Bring the packet to School
	6. Bring your Supply Fee to school
	7. Check this website for other information: prices, calendars, Family Handbook, monthly newsletter and much more.



For office use only
Year:
Class/Teacher:
Supply Fee:
Date of Deposit:

Enrollment Information

St. Peter's Episcopal School

321 St. Peter Street
Kerrville, TX 78028
stpeterskerrville@hotmail.com

830-257-0257
Fax: 830-257-0283
www.stpeterskerrville.com

Child's Full Name: _____

Date of Birth: _____ Age as of Sept 1st: _____ Sex: _____

Mailing Address/City, State, Zip: _____

Primary Phone: _____ Primary E-Mail: _____

(Will be used for school wide Directory and text/E-mail notices)

Father's Name: _____

Home Address: _____

Home/Cell Phone: _____

Driver's License No: _____

Employer: _____

Occupation: _____

Work Phone: _____

Mother's Name: _____

Home Address: _____

Home/Cell Phone: _____

Driver's License No: _____

Employer: _____

Occupation: _____

Work Phone: _____

Emergency Contact/Release of Child

I authorize St. Peter's Episcopal School to release my child to the following people and they may be called in an emergency. Please list names in the order you want people contacted.

Name	Address	Relationship	Phone	Driver's License No.

Revised January 17, 2018

X _____ _____

Signature required by Parent or Legal Guardian Date

Pertinent Information

List all information the staff needs to provide for the well-being of your child.

Parents are: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Child lives with: ☐ Both parents ☐ Mother ☐ Father Other: _____

If divorced or separated, state custody arrangements (Use back of this page). Copies of court documents might be requested by the School Office.

Is child adopted? ☐ Yes ☐ No Does he/she know? ☐ Yes ☐ No

Was child premature? ☐ Yes ☐ No Church preference: _____

Child's previous group experience: _____

Other members of the family (and/or other people living in the household):			
Full Name	**Age**	**Date of Birth**	**Sex**

Home language: _____ Race (optional): _____

Hospitalization in last 12 months? ☐ Yes ☐ No Describe: _____

Serious illnesses or injuries? ☐ Yes ☐ No Describe: _____

Special screenings for motor development? ☐ Yes ☐ No When _____ With whom _____

Special screenings for developmental delay? ☐ Yes ☐ No When _____ With whom _____

Copies of screening results might be requested by the School Office.

Hours child will be in school: _____ to _____

Date of admission (the first day actually present at school): _____

St. Peter's School does not exclude students because of race, ethnicity, sex or religion.
Parents/Legal Guardians are welcome to visit any time during operating hours.

X _____ _____

Signature required by Parent or Legal Guardian Date

Allergy Information

☐ Not applicable Known allergies (food, airborne, etc.): _____

Describe reaction: _____

Describe treatment plan: _____

List any health concerns: _____

Long Term Medication

☐ Not applicable Name of Medicine: _____

Dosage: _____ Time(s) to be given: _____

Please note that a Medical Action Plan might be requested from your physician

Short term medication—separate forms required.

Medical Insurance Company: _____ Policy Holder Name: _____

Address: _____ Policy/Group No: _____

Agent Name: _____ Phone No: _____

Emergency Medical/Dental Information

If a medical emergency should occur while my child is in the care of St. Peter's School, I authorize the Director or an employed staff member to take my child to the **nearest emergency room or medical center**. I give my consent for any and all necessary treatment when my child is in the care of this medical facility.

Physician's Name: _____ Phone: _____

Address: _____

Dentist Name: _____ Phone: _____

Address: _____

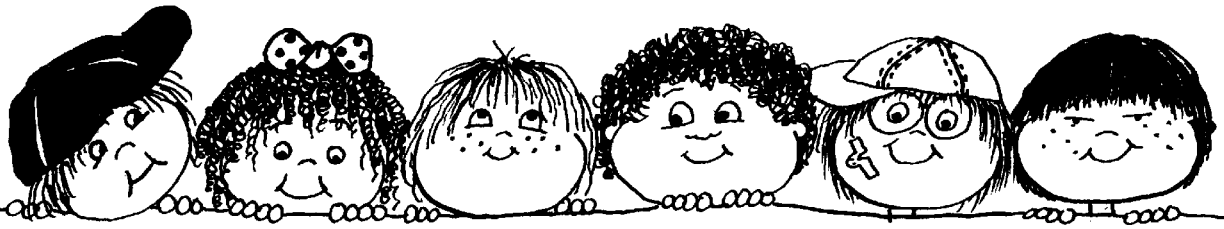
Field Trip/Transportation

I understand that field trips are an integral part of the curriculum, and that I will be asked permission for each field trip as it approaches. I further understand that my child will be transported in the School's bus on all field trips. With this understanding, I hereby give my permission for the staff and volunteers of St. Peter's Episcopal School to take my child on field trips while he/she is in the program. Also, St. Peter's School has permission to take my child on walks or excursions off the school premises for field trips conducted and supervised by St. Peter's School staff. Note: 48 hour notice required for all field trips.

I have completed this application and **Pertinent Information** with accuracy and understand that I have given consent to St. Peter's Episcopal School for **Emergency Contact/Release of Child, Emergency Medical/Dental Information and Field Trip/Transportation.**

X _____ _____

Signature required by Parent or Legal Guardian Date



Receipt of Health Form

321 St. Peter Street
Kerrville, TX 78028

830-257-0257
Fax: 830-257-0283

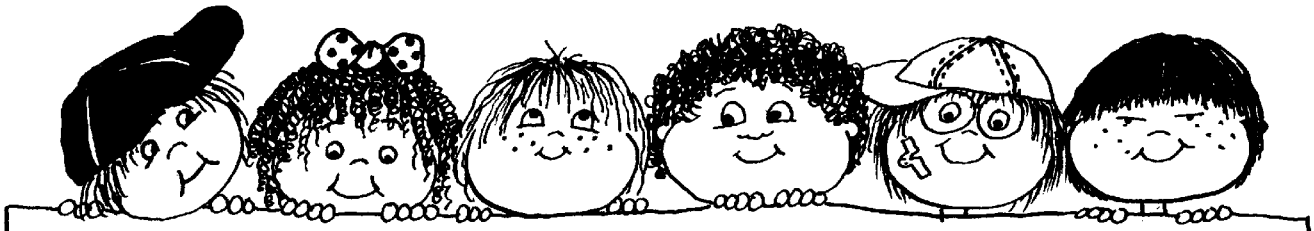
I understand that a current Health Form and immunization record are due in the School Office by the first week of August.

X_____

Signature required by Parent or Legal Guardian

E-Mail: stpeterskerrville@hotmail.com www.stpeterskerrville.com

Revised January 17, 2018



Family Handbook Notification

The St. Peter's Episcopal School Family Handbook can be accessed on the Church website: www.stpeterskerrville.com. Just access the School link to read our Handbook. Copies of the Family Handbook are available on request through the School Office.

My signature below acknowledges that I am responsible for and accept the terms of the Handbook.

X_____

Signature required by Parent or Legal Guardian

Print Parent/Legal Guardian Name:_____

Print Student Name:_____ Date: _____

For office use only
Year:
Class/Teacher:
Registration Fee:
Date of Deposit:

After School Care Registration

St. Peter's Episcopal School

321 St. Peter Street
Kerrville, TX 78028
stpeterskerrville@hotmail.com

830-257-0257
Fax: 830-257-0283
www.stpeterskerrville.com

Child's Full Name: _____

Date of Birth: _____ Age as of Sept 1st: _____ Sex: _____

Mailing Address/City, State, Zip: _____

Primary Phone: _____ Primary E-Mail: _____

Father's Name: _____ **Mother's Name:** _____

Employer: _____ Employer: _____

Work Number: _____ Work Number: _____

Cell Phone: _____ Cell Phone: _____

Emergency Medical Attention

If a medical emergency should occur while my child is in the care of St. Peter's School, I authorize the Director or an employed staff member to take my child to the nearest emergency room or medical center. I give my consent for any and all necessary treatment when my child is in the care of this medical facility.

Emergency Contact/Release of Child

I authorize St. Peter's Episcopal School to release my child to the following people and they may be called in an emergency. Please list names in the order you want people contacted. You must list any people other than the person who signs this form.

Name	Address	Relationship	Phone	Driver's License

Days child will use After School Care: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Approximate time for pick up: _____

I have completed this application with accuracy and understand that I have given consent to St. Peter's Episcopal School for Emergency Medical Attention and Release of Child.

X _____ _____

Signature required by Parent or Legal Guardian Date

Revised January 17, 2018

Health Form

St. Peter's Episcopal School

321 St. Peter Street
Kerrville, Texas 78028
830-257-0257
Fax: 830-257-0283
Website: www.stpeterskerrville.com
E-Mail: stpeterskerrville@hotmail.com

Child's Name: _____ Child's DOB: _____

Parent Name: _____ Address: _____

Immunization Record

The immunization record is due in the school office by the first week of August. The Texas Department of Health mandates this record and visits the school to inspect student health records for this purpose.

**** Please attach a copy of your child's immunization record. ****

	DPT	OPV	Hepatitis B	MMR	HIB	Varicella (Chickenpox)	Pneumococcal (Prevnar)	Hepatitis A
1st Dose								
2nd Dose								
3rd Dose								
4th Dose								
5th Dose Kinder entrance								

Note: Month, day and year of each immunization is required.

Vision and Hearing Record

Note: Required for Pre-K (4's) and Kindergarten students

Vision	R 20/_____	L 20/_____	☐ Pass	☐ Fail
Date Tested:				

Hearing	1000 Hz	2000 Hz	4000 Hz	
R				☐ Pass
L				☐ Fail
Date Tested:				

I certify this child has been examined by me and is physically able to take part in the program at St. Peter's Episcopal School.

X _____ _____

Signature or stamp of licensed physician Date

Revised January 17, 2018