2021-2022

Welcome to

St. Peter
Prince of Apostles
SCHOOL

A Nationally Recognized Blue Ribbon School of Excellence

1986 and 2006

For registration the following documents are required:

1. Copy of Students Original Birth Certificate (required)
2. Copy of Complete/Current Immunizations (required)
3. Copy of Baptism/Communion Certificate (If applicable)
4. Copy of Present Report Card
5. Copy of Standardized Tests Scores
6. Copy of any/all Official Court Documents attached to your child.

"St. Peter Prince of Apostles Catholic School admits students of any race or national origin to programs and activities of the school with all rights and privileges. Equal opportunity and access is provided to persons without regard to race, national origin, or gender in the implementation of employment policies and procedures. This policy is in compliance with Title VI and VII of the Civil Rights Act of 1964 and Title IX of the Education Amendments of 1972".

THANK YOU!

Student Demographics

2021/2022

Student Name: _____ Address _____ Siblings _____ Medical _____

Last: _____ City: _____ _____ Doctor: _____

First: _____ State: _____ Zip: _____ _____ Phone: _____

Middle: _____ _____ Hospital: _____

Nickname: _____ _____ Blood Type: _____

D.O.B: _____ Permission to Treat? Yes No

SSN: _____ Gender: _____

Hm. Phone: _____ Ethnicity: _____

E-Mail: _____ Grade: _____

	Custodial Father's Information		Custodial Mother's Information		Emergency Contact		Emergency Contact	
Name:								
Relationship:								
Hm. Phone:								
Work #:								
Cell #:								
E-Mail:								
Occupation:								
Company:								
Custody?	Yes	No	Yes	No	Yes	No	Yes	No
Emergency:	Yes	No	Yes	No	Yes	No	Yes	No
Receive mailings:	Yes	No	Yes	No	Yes	No	Yes	No
Address:								
City:								
State:		Zip		Zip		Zip		Zip

Additional Student Information: **2021/2022**

Child resides with: _____Both Parents _____Mother _____Father _____ Other (specify)
Total # children in family: _____
 # Boys _____ # Girls _____
Rank of this child: _____
Citizenship: _____US _____Other (Specify)
Language Spoken at Home: _____English _____Other (Specify)
After School Care: _____Daily _____Drop in only

Additional Family/Parent Information:

Mother:
Marital Status: _____Single _____Married _____Remarried _____Divorced/Separated _____ Deceased
Highest Level of Education_____

Father:
Marital Status: _____Single _____Married _____Remarried _____Divorced/Separated _____ Deceased
Highest Level of Education_____
Is there a signed, legal custody agreement? _____Yes _____No
Does the school have a copy? _____Yes _____No

Public School Information:

The Public School District you currently reside in: _____
The name of the Public Elementary/Middle School your child would attend: _____
County: _____
Student is transferring from: _____ (New/Transferring Students Only)

Religious Information:

Catholic: _____Yes _____No Religion of Student: _____
Church/Parish: _____
Date of Baptism: _____/_____/_____
Date of 1st Eucharist: _____/_____/_____
Date of 1st Reconciliation: _____/_____/_____

Important Information Regarding Transfer Students:

According to Archdiocesan policy, final acceptance of transfer students to this school will be contingent upon satisfaction of any and all financial obligations with previous school(s). Financial status with previous school(s) will be verified as part of your application to this school. Please indicate with your signature below that you understand this policy.

Parent/Guardian Signature: _____
Date:_____

St. Peter Prince of Apostles School

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Student Name: _____ Date of Birth _____

St. Peter Prince of Apostles School is requesting that you authorize the release of specified records containing confidential information regarding the above student who is transferring to St. Peter Prince.

St. Peter Prince of Apostles School has permission to request records from:

School (required)
Name _____
Address _____
_____ **Zip** _____

Primary Physician
Name _____
Address _____
_____ **Zip** _____

Psychiatrist / Psychologist
Name _____
Address _____
_____ **Zip** _____

RECORDS TO BE REQUESTED

Transcript	***ARD/IEP - Required if Available***
Medical/Immunization Records	***Academic Assessment - Required if Available***
OT/PT Assessment	Psychological Assessment
Vision/Hearing Screenings	Speech Language Assessment
Discipline File	Comprehensive Assessment

_____ Yes _____ No I have been fully informed and understand the school's request for my consent for release of the student's records as described above. This information will be released upon receipt of my written consent.

_____ Yes _____ No I understand that my consent is voluntary and may be revoked in writing at any time.

_____ Yes _____ No I grant consent for release of records as specified above.

Parent Signature: _____ **Date:** _____

Please Mail to:
St. Peter Prince of Apostles School
112 Marcia Place, San Antonio, TX 78209
(210) 824-3171

Department of Catholic Schools
Archdiocese of San Antonio
2718 W. Woodlawn Ave
San Antonio, TX 78228
210-734-2620 • Fax 210-734-9112
www.sacatholicschools.org

STUDENT HEALTH FORM

School Year: _____ **Grade:** _____ **Homeroom Teacher:** _____

Student's Name: _____ _____ **M / F**
Last Name First Name M.I. Date of Birth Gender

Primary Address: _____
Street Address City State Zip

It is the Texas Catholic Conference of Bishops policy that every student in a Catholic School in the State of Texas be immunized against vaccine preventable diseases caused by infectious agents in accordance with the immunization schedule adopted by the Texas Department of State Health Services.

Children will be screened as set forth by the Texas Department of State Health Services for hearing, vision, scoliosis and acanthosis nigricans. The school follows the required screening schedule from the State of Texas.

WHERE CAN PARENTS/GUARDIANS BE REACHED?

Mother/Guardian Name: _____ **Primary Phone:** _____

Address if different: _____ **Secondary Phone:** _____

Work Place: _____ **Work Phone:** _____

Work Address: _____ **Email:** _____

Father/Guardian Name: _____ **Primary Phone:** _____

Address if different: _____ **Secondary Phone:** _____

Work Place: _____ **Work Phone:** _____

Work Address: _____ **Email:** _____

Please list designated persons allowed to assume temporary care of your child if you are not available. **ONLY** the designated individuals listed below will be able to pick-up your child/children from school. ***Changes or additions to this form must be made in writing.***

1) Name: _____ **Primary Phone:** _____

Address: _____ **Secondary Phone:** _____

Relationship: _____ **Work Phone:** _____

2) Name: _____ **Primary Phone:** _____

Address: _____ **Secondary Phone:** _____

Relationship: _____ **Work Phone:** _____

** You may list additional Authorized Persons to assume temporary care of your child/children on the reverse.
ONLY the designated people will be able to pick up your child/children from school.**

Student's Name: _____

3) Name: _____ **Primary Phone:** _____

Address: _____ **Secondary Phone:** _____

Relationship: _____ **Work Phone:** _____

4) Name: _____ **Primary Phone:** _____

Address: _____ **Secondary Phone:** _____

Relationship: _____ **Work Phone:** _____

*** Is any person, including mother or father, legally restrained from picking up this child?** Yes / No
If yes, please give a brief description of the restrictions in the space below:

CONDITION	Moderate	Severe	COMMENTS
Allergy - Drug/Other			
Asthma			
Accident or Illness**			
Blood Disorder			
Cardiac Disease/Problem			
Chicken Pox (**date required**)			
Congenital Deformity			
Diabetes			
Hearing Loss			
Hypertension			
Neurological Disorder			
Otitis Media (Ear Infection)			
Seizure Disorder (Epilepsy)**			
Surgery – Serious**			
Urinary Problem			
Vision Loss			
INJURIES			
Head**			
Back**			
OTHER:			

** Details required, please use COMMENTS section.

List all medications (prescription, over-the counter, and herbal) that your child takes regularly: _____

_____

Primary Physician's Name: _____ **Phone:** _____

Hospital Preference: _____

Dentist: _____ **Phone:** _____

In the case of accident or illness, I request the school contact me. If the school is unable to reach me, the school has permission to take whatever action they deem necessary for the health and welfare of my child in the event of an emergency. I give permission for release of information on this form for confidential use in meeting my child's health and educational needs in school.

Parent/Guardian Signature: _____ **Date:** _____

Parent/Guardian Name Printed: _____