# 2018-2019

# Welcome to

## 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 2018/2019

| 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:** **2018/2019**

**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 |

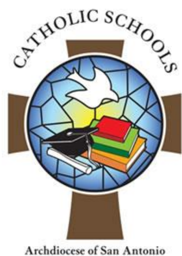
_____ Yes _____ No I have been fully informed and understand the school's request for my consent for release of the student's records as described above. This information will be released upon receipt of my written consent.

_____ 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:** ________________________________________________