



St. Peter's Episcopal School

Janet Boutin, School Director

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

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

Attached is our 8 page application. Checklist to complete:

1.	Please type in all pages 1 thru 5 and 8. Complete all fields. Note: Children entering 3's and older programs must be fully potty trained.
2.	Parent/Guardian signature or electronic signature required on pages 1 thru 5 and 8. Primary Cardholder must sign Page 8 (if you choose this payment option).
3.	Download to print.
4.	Health Form (page 6) must be signed and completed by your child's physician.
5.	Return the packet to School when fully completed. Please note that we are no longer able to honor teacher requests.
6.	Pay your Supply Fee. Checks payable: St. Peter's School
7.	See My Procure information attached.
8.	Check this website for other information: prices, calendars, Family Handbook, monthly newsletter, payment portal and more.

**Access our [School Calendar](#) to start
planning ahead now.**

For office use only	
Admission Info	
Start Date:	
End Date:	
Date of Deposit:	

Enrollment Information

St. Peter's Episcopal School

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For office use only	
Year:	
Class/Teacher:	
Supply Fee:	
Payment:	

Child's Full Name:		Sex:	
Date of Birth:		Age as of Sept 1 st: Note: 3's and older programs must be potty trained.	
Mailing Address/City, State, Zip:			
Child's Home Address (If different):			
Primary Contact Release #1 (Contact must be parent/guardian)		Contact Release #2 (Contact must be parent/guardian)	
Name:		Name:	
Physical Address:		Physical Address:	
E-Mail Address:		E-Mail Address:	
Cell Phone:		Cell Phone:	
Cell Phone Provider:		Cell Phone Provider:	
Driver's License No:	State:	Driver's License No:	State:
Employer/Occupation:		Employer/Occupation:	
Work Phone:		Work Phone:	

Emergency Contact/Release of Child

I authorize St. Peter's Episcopal School to release my child only to the following people and they may be called in an emergency. Please list names in the order you want people contacted. **Note:** Primary #1 and #2 above are automatically authorized for release; do not list #1 and #2 below. One Additional Release Person Required below.

Name	Address & City/State	Relationship	Area Code & Phone	License No. & State

Revised February 4, 2025

X
X

Signature Required by Parent/Legal Guardian Completing Form Date

Pertinent Information

Parents are: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed Other: _____

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

Note: If divorced, separated or state custody arrangements; Copies of court custody documents will be required by the School Office.

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

Was child premature? ☐ Yes ☐ No Church Preference: _____ ☐ N/A

Child's previous group experience: _____ ☐ N/A

Estimated hours child will normally be in school: Check In Time: _____ Check Out Time: _____

Note: School operating hours Monday-Friday, 7:30am-5:30pm

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

Home language: _____

Race (optional): _____

Previous serious illness/Hospitalization in last 12 months? ☐ Yes ☐ No Describe: _____

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

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

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

Note: Children 3 years and older with disabilities or special needs will be referred to area public school services and not granted enrollment when it is necessary to alter the nature of the program.

<input type="checkbox"/> Yes <input type="checkbox"/> No My child has been examined within the past year by a health care professional and is able to participate in the program. Within 12 months of admission, I will return the doctor signed Health Form to the School Office.	
Name of Health Care Professional:	Address of Health Care Professional:

X

X

Signature Required by Parent/Legal Guardian Completing Form

Date

Allergy Information

Known allergies (food, airborne, environmental etc.) _____

Describe reaction: _____

Describe treatment plan: _____

List any health concerns: _____ ☐ Not applicable

Note: A Food Allergy and Anaphylaxis Emergency Care Plan will be requested from your physician.

Long Term Medication

Name of medicine: _____ Existing Illness _____

Dosage: _____ Time(s) to be given: _____ ☐ Not applicable

Note: A Medical Action Plan might be requested from your physician. Short term medication-separate forms required.

Insurance Information

Medical Insurance Company: _____ Policy Holder Name: _____

Address: _____ Policy/Group No: _____

Agent Name: _____ Phone No: _____

☐ Not applicable/Private pay

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 call 911 to transport or take my child to the nearest emergency room or medical center (Peterson Regional Medical Center located at 551 Hill Country Drive, Kerrville, TX 78028; 830-896-4200). 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 No: _____

Address: _____

Dentist Name: _____ Phone No: _____

Address: _____

Field Trip/Transportation

I give my consent for my child to participate on field trips while they are enrolled in the program. St. Peter's School has permission to take my child on the school bus, walking trips and excursions off the school premises for school activities. The School does not participate in swimming pool activities. All will be conducted and supervised by St. Peter's School staff.

Note: 48 hour notice will be given 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.

St. Peters' School does not exclude students because of race, ethnicity, sex or religion. Parents/Legal Guardians are welcome to visit anytime during operating hours (unless Health and Licensing Authorities mandate otherwise).

My signature verifies that I attest and agree to all terms of this application.

X

X

Signature Required by Parent/Legal Guardian Completing Form

Date

Receipt of Health Form

I understand that my child's current Health Form and immunization records or current affidavit are due in the School Office by the first week of August.

Note: These records are required by the first day of school to secure your child's enrollment.

X

X

Signature Required by Parent/Legal Guardian

Date

Family Handbook Notification

St. Peter's Episcopal School Family Handbook can be accessed on the Church website: www.stpeterskerrville.com. Copies of the Family Handbook and the School's Policies and Procedures can also be viewed in the School Office.

Note: My signature below acknowledges I am responsible for and accept the terms of the Family Handbook.

X

X

Signature Required by Parent/Legal Guardian:

Date:

Print Parent/Legal Guardian: _____

Print Student Name: _____

Parent/Guardian Rights

Parent/Guardian's Rights In Child Care Facilities (42.042710) can be accessed on the [Texas Health and Human Services](http://www.texashealthandhuman-services.org) (THHS) website.

Note: My signature below acknowledges I have been made aware of these guidelines.

X

X

Signature Required by Parent/Legal Guardian

Date

Meals and Snacks

If your child is staying after 12:00 p.m. for After School Care, families must pack a lunch from home. Please pack a lunch free of choking hazards, free of food allergy ingredients and meets your child's daily nutritional needs. Families are responsible for providing a morning snack and the School will provide an afternoon snack.

Note: For special dietary needs please contact the School Office concerning providing your own child's snacks.

Note: My signature below acknowledges I have been made aware of these guidelines.

X

X

Signature Required by Parent/Legal Guardian

Date

For office use only	
Admission Info	
Start Date:	
End Date:	
Date of Deposit:	

After School Care Registration

St. Peter's Episcopal School

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For office use only	
Year:	
Class/Teacher:	
Supply Fee:	
Payment:	

Child's Full Name:		Sex:	
Date of Birth:		Age as of Sept 1st:	
Mailing Address/City, State, Zip:			
Primary Contact Release #1 (Contact must be parent/guardian)		Contact Release #2 (Contact must be parent/guardian)	
Name:		Name:	
Physical Address:		Physical Address:	
E-Mail Address:		E-Mail Address:	
Cell Phone:		Cell Phone:	
Cell Phone Provider:		Cell Phone Provider:	
Driver's License No:	State:	Driver's License No:	State:
Employer/Occupation:		Employer/Occupation:	
Work Phone:		Work 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 call 911 to transport or 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 only to the following people and they may be called in an emergency. Please list names in the order you want people contacted.

Note: Primary #1 and #2 are automatically authorized for release. One Additional Release Person Required below.

Name	Address & City/State	Relationship	Area Code & Phone	License No. & State

Days child will use After School Care: ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ As Needed

Approximate time for pick up: _____

Note: School closes promptly at 5:30pm.

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. I understand it is my responsibility to keep my school account current in order to use ASC services.

X

X

Signature Required by Parent/Legal Guardian Completing Form

Date



Health Form

St. Peter's Episcopal School

naeyc[®]

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

Parent Name: _____ Address: _____

Immunization Record/Or Affidavit

This doctor signed form and immunization record or current affidavit is due in the school office by the first week of August. The Texas Department of Health mandates these records and visits the school to inspect student health records for this purpose.

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

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

Vision and Hearing Record

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

Vision	R 20/ <input style="width: 40px;" type="text"/>	L 20/ <input style="width: 40px;" type="text"/>	<input type="checkbox"/> Pass	<input type="checkbox"/> Fail
Date Tested:				
Hearing	1000 Hz	2000 Hz	4000 Hz	<input type="checkbox"/> Pass <input type="checkbox"/> Fail
R	<input style="width: 100px;" type="text"/>	<input style="width: 100px;" type="text"/>	<input style="width: 100px;" type="text"/>	
L	<input style="width: 100px;" type="text"/>	<input style="width: 100px;" type="text"/>	<input style="width: 100px;" type="text"/>	
Date Tested:				

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

X

X

Doctor Signature/Stamp Only

Date:

Fax or email form to School Office.



Diocese of West Texas

St. Peter's Episcopal School

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Dear School Families,

St. Peter's Episcopal School is pleased to offer [MYProcure](#), a free online portal for you to access account information and easily pay tuition. MyProcare is safe, secure and created with your convenience in mind.



[Log in today!](#)

1. Go to www.myprocare.com. To access, use Desk Top, Google Chrome Web Browser.
2. Enter your email address (the email you have on file with St. Peter's School) and choose GO.
3. Enter the confirmation code sent to your email, choose a password, and press GO.
4. Then use the PAY button to make a payment by credit card, debit card or checking account.
5. For your convenience, the Tuition Express Automated Payment Processing form is attached for credit card or checking account payments (choose one). These payments will process all balances owed to the School on the 15th of each month. If 15th falls on weekend or holiday, payment will process on the following business day.

Note: Only turn in, if you choose to use this service.

Thank you,
Janet Boutin
School Director

St. Peter's School is affiliated with the following:





Automated Payment Processing Safe – Convenient – Easy

We are excited to offer the safety, convenience and ease of Tuition Express® — a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR **BANK ACCOUNT** and **CREDIT CARD**

I (we) hereby authorize (business name) St. Peter's Episcopal School to initiate credit card charges to the below-referenced credit card account (Section A) OR, initiate debit entries to my (our) checking or savings account, indicated below (Section B). To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. _____ (initial) Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

Complete One Section Only

Section A (Credit Card)

Cardholder Name	Phone #
Cardholder Address	City State Zip
Account Number	Expiration Date
<div style="display: flex; justify-content: space-between;"> X Date </div>	

Primary Cardholder Signature

Section B (Bank Account)

(OR)

Your Name	Phone #
Address	City State Zip
Bank or Credit Union Name	Bank or Credit Union Address City State Zip
Routing Transit Number (see sample below)	Account Number (see sample below) <input type="checkbox"/> Checking <input type="checkbox"/> Savings

Authorized Signature

Date

For Official Use Only

Date Received

Employee Signature

John Sample Mary Sample 123 Nice Street Anytown, USA	BANK OF THE WEST 555-555-5555	00226
Pay to the order of: Attach Voided Check Here \$		
Deposit slips not accepted Dollars		
1234567890	18003368	0226
Routing Number	Account Number	Check Number

A service of

