KILBOURNE PARK BAPTIST CHURCH PRESCHOOL
4205 Kilbourne Road • Columbia, SC 29206
Telephone: (803) 787-3372 • Fax: (803) 787-3379
Stephanie Pantoja, Director: stephanie@kilbournepark.org

2021-2022 APPLICATION FOR 4K ADMISSION

Application Status:
☐ My child is currently enrolled in KPBC Preschool.
☐ My child's sibling is currently enrolled in KPBC Preschool.

Application to Enter:
☐ 4K (M-F $300)*

*Tuition covers your child's care from 8:30am – 12pm.
We offer Early Care (8am – 8:30am) and Extended Care (12pm – 3pm) at a rate of $7/hour for the first child. Two or more children will be charged for extended care at a rate of $6/hour.

***A $40 supply fee per child will be billed to your account in September and January.**

CHILD INFORMATION:

Full name ______________________________ Date of Birth ____________
(First) *(Middle)* *(Last)*

Preferred Name ______________________________ Sex ____________

Street Address ______________________________ Zip Code ____________

FAMILY INFORMATION:

Mother's Name ______________________________

Cell ____________________ Work ____________________

Email ______________________________

Employer Name and Address ______________________________

Father's Name ______________________________

Cell ____________________ Work ____________________

Email ______________________________

Employer Name and Address ______________________________

Church Membership ______________________________

REGISTRATION GUIDELINES

1. $150 registration fee is non-refundable. *You will be billed a $40 supply fee per child in September and January.*
2. An immunization certificate showing your child is current with all vaccinations is required by DHEC the first day of school. Immunizations must be kept current throughout the school year or we are required to ask you to withdraw your child.
3. I give Kilbourne Park Preschool permission to photograph and post pictures of my child on the Kilbourne Park Preschool social media pages.

________ ***Initial – I have read and understand the guidelines listed above.***

OFFICE USE ONLY:

Date enrolled ____________ Registration paid - ck #____________ SC Cert of Imm ____________

South Carolina Department of Social Services
Child Care Regulatory Services

GENERAL RECORD AND STATEMENT OF CHILD'S HEALTH FOR ADMISSION TO CHILD CARE FACILITY

This form is to be completed for each child at the time of enrollment in the child care facility, updated as needed when changes occur, and maintained on file at the facility.

GENERAL INFORMATION: (to be completed by Parent or Guardian)

Name of Facility: ______________________ County: Select County ...

Address: ______________________
Street Address – no Post Office Boxes City, State, Zip

Child's Name: ______________________
Last First Middle Initial Nick Name

Date of Birth: ______________ Enrollment Date: ______________

Child's Current Home Address: ______________________
Street Address City, State, Zip

Parent/Guardian's Full Name: ______________________

Home Phone: __________ Work Phone: __________ Other Phone: __________

Parent/Guardian's Full Name: ______________________

Home Phone: __________ Work Phone: __________ Other Phone: __________

You must have two individuals who have the authority to obtain emergency medical treatment for the child.

1. Person responsible if parent/guardian unavailable for emergency medical services:

____
Full Name Relationship

Address: ______________________
Street Address City, State, Zip

Telephone Number(s): ______________ Family Code Word(s): __________

2. Person responsible if parent/guardian unavailable for emergency medical services:

____
Full Name Relationship

Address: ______________________
Street Address City, State, Zip

Telephone Number(s): ______________ Family Code Word(s): __________

Is Child currently enrolled in school? (5K up to 6 years old) ❑ Yes ❑ No

My Child will regularly attend this facility **FROM** ________ am/pm **TO** ________ am/pm

If Child is a drop-in, indicate hours of care: **FROM** ________ am/pm **TO** ________ am/pm

Check all days Child will regularly attend this facility: ❑ **Mon** ❑ **Tue** ❑ **Wed** ❑ **Thurs** ❑ **Fri** ❑ **Sat** ❑ **Sun**

Check all meals Child will receive daily: ❑ **Meals are not offered** ❑ **Breakfast** ❑ **Morning Snack** ❑ **Lunch** ❑ **Afternoon Snack** ❑ **Dinner** ❑ **Evening Snack**

HEALTH INFORMATION: (to be completed by Parent or Guardian)

Family Physician or Health Resource: ______________________
Name

____
Street Address City, State, Zip Telephone

Emergency Care Provider: ______________________
Emergency Facility Name

____
Street Address City, State, Zip Telephone