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

2025-2026 APPLICATION FOR INFANTS TO TWOS ADMISSION

MONTHLY TUITION (SEPTEMBER-MAY):

☐ Infants (M-F $390)*	☐ Infants (MWF $330)*	☐ Infants (T/Th $305)*
☐ Ones (M-F $375)*	☐ Ones (MWF $325)*	☐ Ones (T/Th $300)*
☐ Twos (M-F $370)*	☐ Twos (MWF $320)*	☐ Twos (T/Th $290)*

*Tuition covers your child's care from 9am – 12pm.
*We offer Early Care (8am – 9am) and Extended Care (12pm – 3pm) at an additional cost.
The cost of early/extended care is $9 per hour if scheduled at the start of each month or $11 per hour for drop in.

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 _____

REGISTRATION GUIDELINES:

1. Registration fee is due at the time of registration; it is non-refundable. Registration fee is $200.
2. $65 supply fee per child will be added to your September and January invoices.
3. Upon registering, an immunization certificate showing your child is current with all vaccinations is required. In compliance with DHEC, immunizations must be kept current throughout the school year or we are required to ask you to withdraw your child. **We do not take immunization exemptions of any kind.**
4. 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 _____

EMERGENCY: If parents cannot be located, in case of illness or accident, notify:

1. Name _____ Relationship _____
   Phone Number _____
2. Name _____ Relationship _____
   Phone Number _____

If medical assistance is required, it is requested that the following physician or dentist be notified:

Physician _____ Phone Number _____

Address _____

Health Insurance Provider _____ Id/Grp # _____

Dentist _____ Phone Number _____

Address _____

List any known allergy your child has: _____

_____

MEDICAL TREATMENT RELEASE FORM

I give permission for medical treatment of my child, _____, by a doctor and/or hospital in case of an emergency when neither parent(s) nor person(s) listed as emergency contacts can be reached.

I hereby authorize the Director or Assistant Director of Kilbourne Park Baptist Church Preschool to execute any and all documents including any necessary releases on my behalf, which might be required, by any medical facility or physician to perform any emergency care, on account of any accident or illness sustained or incurred by my child, named above, while attending Kilbourne Park Baptist Church Preschool.

I further agree that in consideration of my child's attending Kilbourne Park Baptist Church Preschool, I will hold Kilbourne Park Baptist Church Preschool, and its agents and servants, harmless from any action by me or my child on account of any injury or damage sustained or suffered by my child while attending Kilbourne Park Baptist Church Preschool or Field Trips.

I certify that my child, named above, is in good health and requires no special medical care or treatment while at Kilbourne Park Baptist Church Preschool.

_____ _____

PARENT'S SIGNATURE DATE

Below is a list of additional relatives/sitters who have permission to pick up my child:

Name _____ Phone Number _____

Name _____ Phone Number _____

Name _____ Phone Number _____

Name _____ Phone Number _____

 DSS Registration #234

Reset

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: Kilbourne Park Baptist Church County: Richland

Address: 4205 Kilbourne Road Columbia, SC 29206
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

Dental Care Provider: _____
Name

_____
Street Address City, State, Zip Telephone

Health Insurance Provider: _____

Certificate of Immunization: ❑ Yes ❑ No ❑ N/A Please explain: _____

My child has the following health conditions such as allergies, asthma, diabetes, epilepsy, etc., and/or takes the following medications on a regular basis:

Additional Comments: _____

I certify that to the best of my knowledge _____
Child's Name

is in good mental and physical health and able to participate in the child care program at

_____
Name of Child Care Facility

Signature: _____ Date: _____
Parent or Guardian

Signature: _____ Date: _____
Director/Operator/Staff Designee