



# KILBOURNE PARK BAPTIST CHURCH PRESCHOOL

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“So that you may live a life worthy of the Lord and please Him in every way.” Colossians 1:10

## 2026-2027 APPLICATION FOR 5K ADMISSION

### MONTHLY TUITION (SEPTEMBER-MAY):

5K (M-F \$410)\*

\*Tuition covers your child's care from 8:30am – 12pm.

\*We offer Early Care (8:30am – 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. The registration fee is \$200.
2. \$75 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 \_\_\_\_\_

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: \_\_\_\_\_

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

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