

For Office Use Only
 Tuition: _____
 Class: _____
 Days Attending: _____



A Ministry of First Baptist Church
 200 Branchview Drive; PO Box 643
 Concord, NC 28026

For Office Use Only
 Application Date: _____
 Registration Fee: _____
 Cash _____ Check # _____

Enrollment Application 2021-2022 School Year

Phone: 704 786-9167 ext. 6 Fax: 704 795-3638 Email: abcpreschool@fbccconcord.org

Student Name: _____

Additional Information:

- A copy of your child's **birth certificate and current immunization records** will need to accompany the enrollment application. (If we already have your child's birth certificate, only his or her current immunization records are required.)
- Registration fee is \$60.00 and is due when you return your child's enrollment application to secure his or her placement in a class. (Non-refundable)
- **Hours:** 8:45am—12:30pm
- **Tuition:**
 - 2 day classes: \$140.00 per month
 - 3 day classes: \$170.00 per month
 - 5 day classes: \$240.00 per month

*Each additional child enrolled will receive a 10% discount on tuition.

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ABC Preschool values your opinion and input in making class arrangements. Please place a "1" next to your first preference in class, then a "2" next to your second preference. After completing the attached enrollment application, please return it along with your registration fee. *Also, please understand that the actual class arrangement will depend on the amount of interest, the ability to staff a particular request, and the monetary feasibility of providing for that class.*

The cut off birth date for each class is August 31st of the current year.

_____ 2 day **One year old class** (\$140 per month) ***Depending on the interest level***

_____ 3 day **One year old class** (MWF) (\$170 per month)

_____ 2 day **Two year old class** (Possibly T/TH with enough interest) (\$140 per month)

_____ 3 day **Two year old class** (MWF) (\$170 per month)

_____ 5 day **Two year old class** (M-F) (\$240 per month)

_____ 3 day **Three year old class** (MWF) (\$170 per month)

_____ 5 day **Three year old class** (M-F) (\$240 per month)

_____ 3 day **Four year old class** (MWF) (\$170 per month)

_____ 5 day **Four year old Transitional - Kindergarten (TK) Class** (M-F) (\$240 per month)



CHILD'S NAME: _____
First Middle Last

Name child responds to if different than above: _____

Date of Birth: _____ Male ____ Female ____

Child's Age as of August 31, 2021: _____

Full Home Address (include zip) : _____

Home Phone # (if Available) : _____

Email Address: _____

MOTHER'S (GUARDIAN) NAME: _____

Employer: _____

Cell Phone #: _____ Other Phone #: _____

FATHER'S (GUARDIAN) NAME: _____

Employer: _____

Cell Phone #: _____ Other Phone #: _____

Parents of child are: ____ Married ____ Divorced ____ Separated ____ Other: _____

Child Lives with: ____ Both ____ Mother ____ Father ____ Other: _____

Please list siblings and their ages: _____

Family's Place of Worship (optional): _____

What are your expectations for this year? _____

How did you find out about All Because of Christ Preschool? _____

Tell us about your child (special interests, likes/dislikes, fears, sleeping or eating habits, etc.):

Is your child potty-trained? : _____ (3 and 4 year olds must be potty-trained.)



PERSONS AUTHORIZED TO PICK UP CHILD
(other than parents/guardians)

NAME: _____ Relationship to child: _____

Cell #: _____ Other #: _____

Child knows this person as: _____

NAME: _____ Relationship to child: _____

Cell #: _____ Other #: _____

Child knows this person as: _____

NAME: _____ Relationship to child: _____

Cell #: _____ Other #: _____

Child knows this person as: _____

I, _____, give permission to
(Printed Parent Name)

All Because of Christ (ABC) Preschool to release my child,

_____, to those
(Student's Full Name)

persons listed above in the event that I am unable to pick my child up at
school.

Parent Signature

Date



MEDICAL TREATMENT and EMERGENCY CONTACTS

CHILD'S FULL NAME: _____

Does your child have any allergies? _____

Please list any medical and/or behavioral conditions, medications, etc. that we should be aware of: _____

Name of Child's Doctor: _____

Office Phone #: _____

Name of Child's Dentist: _____

Office Phone #: _____

Hospital Preference: _____

Insurance Carrier: _____ Policy #: _____

Emergency Contacts (After attempting to reach parents/guardians):

1st Contact: _____ Cell #: _____

Other#: _____

2nd Contact: _____ Cell #: _____

Other#: _____

EMERGENCY TREATMENT RELEASE

I hereby authorize ABC Preschool, or its representatives to obtain emergency medical treatment for my child, _____, in the event of a medical emergency or if I or those persons I have designated cannot be reached.

Parent/Guardian Signature

Date