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
2023-2024 School Year

Phone: 704 786-9167 Fax: 704 795-3638 Email: abcpreschool@fbcconcord.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: $170.00 per month
  - 3 day classes: $210.00 per month
  - 5 day classes: $280.00 per month

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

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** (T TH) *($170 per month)*

_____ 3 day **One year old class** (MWF) *($210 per month)*

_____ *5 day **One year old class** (M-F) ($280 per month)*

_____ 2 day **Two year old class** (T TH) *($170 per month) (limited seats)*

_____ 3 day **Two year old class** (MWF) *($210 per month)*

_____ 5 day **Two year old class** (M-F) *($280 per month)*

_____ 3 day **Three year old class** (MWF) *($210 per month) (limited seats)*

_____ 5 day **Three year old class** (M-F) *($280 per month)*

_____ 3 day **Four year old class** (MWF) *($210 per month) (limited seats)*

_____ 5 day **Four year old & Transitional - Kindergarten (TK) Class** (M-F) *($280 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, 2023: _____

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 fully 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