KINGSWOOD PROGRAMS

2026-2027 APPLICATION FOR KINGSWOOD PROGRAMS

June 2026 - May 2027

ENROLLMENT INFORMATION

- Open Enrollment begins March 9, 2026.
- Kingswood reserves the right to combine and/or cancel classes due to minimum enrollment numbers.
- The following items must be returned in order to process your enrollment:
  - Enrollment form
  - Up-to-date immunization record for child (*medical exemptions only*)
  - Child Medical Examination Report (filled out by a physician)
  - Non-refundable $100 registration fee for first child, $50 for any additional children
  - For infants and toddlers, completed feeding plan

- Tuition: Tuition payments are due on the 1st and 15th of each month beginning on September 1st, 2026 with the final payment due May 15th, 2027.
- We are in session September 1, 2026 - May 27, 2027. See school calendar for detailed schedule.
- Children enrolling in our 3 year-old preschool classes or older must be potty trained. If there are any concerns, please contact the Director.
- Parent Orientation: August 27, 2026
- Meet the Teacher: August 31, 2026 - 9:30 am or 6:00 pm

As a religious organization, Kingswood Programs is license exempt, but is inspected annually & approved by the state. Kingswood Programs admits students of any race, color, national or ethnic origin. The school does not discriminate on the basis of race, color, national or ethnic origin in administration of its educational policies, or other school-administered programs.

☐ I have read and acknowledge the Kingswood enrollment information.

☐ I understand that enrollment is on a first-come first-serve basis, and all enrollment items and fees must be returned 30 days in advance of program starting date in order to secure a position.

☐ I understand I may receive one week vacation credit from June 1, 2026 - May 27, 2027, with 2 weeks prior notice through completion of notice form.

Child's Name(s): _____

Parent/Guardian Signature: _____ **Date:** _____

CONTACT

Kingswood Programs
kingswooddirector@kwumc.com

King's Way United Methodist Church
2401 S. Lone Pine Ave.
Springfield, MO 65804
417.881.4398

For Office Use Only:

Date & Time Application Received: _____

Admission Date: _____

Child's Class: _____

Registration fee paid on (date): _____

Monthly Tuition Amount: _____

MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
OFFICE OF CHILDHOOD - CHILD CARE COMPLIANCE

CHILDCAREENROLLMENTFORMFORLICENSE-EXEMPTFACILITIES

FACILITY/PROVIDER NAME	ADMISSION DATE	DISCHARGE DATE
CHILD'S NAME	GENDER	BIRTHDATE
ADDRESS (STREET, CITY, STATE, ZIP CODE)		

IDENTIFYING INFORMATION

MOTHER'S/GUARDIAN'S NAME	HOME TELEPHONE NUMBER
ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS ABOVE ☐	CELL PHONE NUMBER
E-MAIL ADDRESS	
EMPLOYER OR SCHOOL ATTEND	WORK/SCHOOL SCHEDULE
EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)	WORK TELEPHONE NUMBER

FATHER'S/GUARDIAN'S NAME	HOME TELEPHONE NUMBER
ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS ABOVE ☐	CELL PHONE NUMBER
E-MAIL ADDRESS	
EMPLOYER OR SCHOOL ATTEND	WORK/SCHOOL SCHEDULE
EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)	WORK TELEPHONE NUMBER

EMERGENCY CONTACT AND PERSONS AUTHORIZED TO TAKE CHILD FROM FACILITY

(OTHERTHANPARENT) AT LEAST ONEEMERGENCYCONTACT ISREQUIRED.

NAME	RELATIONSHIP TO CHILD	TELEPHONE NUMBERS (CELL, WORK, HOME)
ADDRESS (STREET, CITY, STATE, ZIP CODE)		

NAME	RELATIONSHIP TO CHILD	TELEPHONE NUMBERS (CELL, WORK, HOME)
ADDRESS (STREET, CITY, STATE, ZIP CODE)		

AUTHORIZATIONFOR EMERGENCYMEDICAL CARE

I UNDERSTAND THAT I WILL BE NOTIFIED AT ONCE IN CASE OF AN EMERGENCY WITH MY CHILD, AND I WILL MAKE ARRANGEMENTS FOR MEDICAL CARE OF MY CHILD WITHTHE PHYSICIAN OR HOSPITAL OF MY CHOICE.

IF I CANNOT BE REACHED TO MAKE NECESSARY ARRANGEMENTS, OR IN A CRITICAL EMERGENCY REQUIRING MEDICAL CARE, I AUTHORIZE

_____
DAY CARE PROVIDER

TO CONTACT THE FOLLOWING: **PHYSICIAN OR CLINIC**

NAME	TELEPHONE NUMBER

PREFERRED HOSPITAL

NAME	TELEPHONE NUMBER

ACKNOWLEDGEMENTS		
A	IHAVE BEEN INFORMED OF THE REQUIRED HEALTH AND SAFETY INSPECTIONS AND THE INSPECTION FORMS ARE AVAILABLE FOR REVIEW.	PARENT/GUARDIAN INITIALS
B	WHEN MY CHILD IS ILL, I UNDERSTAND AND AGREE THAT S/HE MAY NOT BE ACCEPTED FOR CARE OR REMAIN IN CARE.	PARENT/GUARDIAN INITIALS
C	I ☐ DO ☐ DO NOT GIVE PERMISSION FOR FIELD TRIPS/EXCURSIONS. I UNDERSTAND I WILL BE NOTIFIED IN ADVANCE WHEN THEY ARE PLANNED.	PARENT/GUARDIAN INITIALS
D	I ☐ DO ☐ DO NOT GIVE PERMISSION FOR THE FACILITY TO TRANSPORT MY CHILD.	PARENT/GUARDIAN INITIALS
E	I HAVE BEEN NOTIFIED THAT I MAY REQUEST NOTICE AT INITIAL ENROLLMENT OR ANY TIME THERE AFTER WHETHER THERE ARE CHILDREN CURRENTLY ENROLLED IN OR ATTENDING THE FACILITY FOR WHOM AN IMMUNIZATION EXEMPTION HAS BEEN FILED.	PARENT/GUARDIAN INITIALS

HEALTH REPORT FOR SCHOOL-AGE CHILD
CHILD'S HEALTH HISTORY AND CURRENT HEALTH PROBLEMS

☐ MY CHILD IS IN GOOD HEALTH, IS ABLE TO PARTICIPATE IN GROUPCARE, HAS NO SPECIAL HEALTH OR MEDICAL REQUIREMENTS.

☐ MY CHILD IS ABLE TO PARTICIPATE IN GROUP CARE BUT HAS SPECIAL HEALTH OR MEDICAL REQUIREMENTS AS LISTED BELOW.

ANY ALLERGIES, SPECIAL MEDICAL CONDITIONS, INCLUDING CHRONIC HEALTH PROBLEMS

ANY SPECIAL MEDICATIONS AND/ OR RESTRICTIONS

PARENT/GUARDIAN SIGNATURE	DATE

FORM TO BE RETAINED FOR ONE YEAR AFTER DISCHARGE.

FILING: FILE FORM IN CHILD'S INDIVIDUAL RECORD.

KINGSWOOD PROGRAMS

Office Use:
_____
_____

PICK-UP RELEASE

Name of Child: _____

Primary Pick Up Person: _____ Phone: _____

Relationship to Child: _____

Persons authorized to take child from Kingswood (other than parents)

Please list the names and phone numbers of any persons other than parent/guardian authorized to take child from facility.

Name: _____ Phone: _____

Relationship to child: _____

Name: _____ Phone: _____

Relationship to child: _____

Name: _____ Phone: _____

Relationship to child: _____

~Must include current vaccination records~

MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
OFFICE OF CHILDHOOD - CHILD CARE COMPLIANCE ***CHILD MEDICAL EXAMINATION REPORT (INFANT/TODDLER/PRE-SCHOOL)***

IDENTIFYING INFORMATION

CHILD'S NAME	BIRTHDATE

CURRENT STATE OF HEALTH

Based on my assessment of this child's medical history, current state of health and my physical examination of the child on ____ / ____ / ____, this child can participate in a child care program. This child has no special care needs unless specified below.

(Date of medical examination must be within the last 12 months.)

PHYSICIAN'S INSTRUCTIONS FOR SPECIALIZED CARE

Complete this section only if child requires special care at a child care facility, e.g. special diets, allergies, ear infections, convulsions, diabetes, asthma, behavior problems, hearing or visual impairment, etc. (Attach additional pages as needed.)

SIGNATURE OF PHYSICIAN OR REGISTERED NURSE UNDER THE SUPERVISION OF A PHYSICIAN	DATE

PHYSICIAN'S OR NURSE'S NAME (PLEASE PRINT)

NAME AND ADDRESS OF CLINIC, GROUP, PRACTICE OR OTHER (MAY USE STAMP.)	IF NURSE IS SUPERVISED BY A PHYSICIAN, INDICATE PHYSICIAN'S NAME (PLEASE PRINT.)
	TELEPHONE NUMBER

TO BE FILED IN CHILD'S RECORD AT CHILD CARE FACILITY

KINGSWOOD PROGRAMS

INFANT/TODDLER CHILD REGISTRATION

***Infant Care**: 6 weeks - 6 months*
***Mobile Infant Care**: 6 months - 12 months*
***Toddler Care**: 12 months - 24 months*

INFANT/TODDLER CARE 7:00 AM - 5:30 PM

☐ Tuesday/Wednesday/Thursday $1,025/month
☐ Monday - Friday $1,335/month

CHILD'S INFORMATION

Child's Full Name (First, Middle, Last): _____
Preferred name/nickname: _____
Sex: M _____ F _____ Birth Date _____/_____/_____
King's Way Member? Yes _____ No _____

FAMILY INFORMATION

Parent/Guardian #1 Name _____
Phone # _____
Email _____
Address _____
☐ Address is the same as child's

Parent/Guardian #2 Name _____
Phone # _____
Email _____
Address _____
☐ Address is the same as child's

Names & ages of all children in the home:

_____

Additional information that might help us know your child better:

_____

_____

_____

_____

_____

_____

MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
OFFICE OF CHILDHOOD – CHILD CARE COMPLIANCE

&

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
CHILD AND ADULT CARE FOOD PROGRAM

INFANT AND TODDLER FEEDING AND CARE PLAN

FOR CHILD CARE FACILITY USE

The formula provided by this child care facility is:	

CHECK A BOX ☐ YES ☐ NO	This child care facility **is participating** in the Child and Adult Care Food Program (CACFP). In order to claim meals and reimbursement, the center must provide infant cereal and other foods when the child is developmentally ready for them.

INSTRUCTIONS (FOR PARENTS)

Please complete for child who is less than 24 months of age. **Update information as needed.** Use a new form or initial/date changes on this form.

CHILD'S NAME	DATE OF BIRTH	DATE ENROLLED

If you or a member of your immediate family ever served in the U.S. Armed Forces, click here for more information about militaryrelated services in Missouri or visit www.dese.mo.gov/veterans-services.

FEEDING INFORMATION

TYPE OF FOOD	FEEDING TIME	KINDS OF FOOD	AMOUNT OF FOOD
Breastmilk			
Formula			
Infant Food			
Table Food			

Who is preparing (mixing) the formula? Check all that apply: ☐ Parent ☐Caregiver

Does your child have any problems with feedings, such as choking or spitting up?

☐Yes Explain: _____

☐No

Does your child use a pacifier? ☐ Yes ☐ No

Note: Pacifiers, if used,cannotbehungaroundaninfant'sneck.Pacifiermechanismsorpacifiersthatattachtoinfantclothingcannotbeusedwith sleepinginfants.

INFANT FEEDING PREFERENCE (under 12 months)

MARK YOUR PREFERENCE (CHECK ALL THAT APPLY).

☐I will provide breast milk for my infant.

☐I will nurse my infant at the center at these times: _____

The facility's formula may be used to supplement feedings if necessary: ☐ Yes ☐ No

If breast milk is unavailable for a feeding, the facility should: _____

☐I request that the formula provided by the child care facility be served to my infant.

☐I will provide infant formula for my infant. Name of formula: _____

☐I request that the child care facility provide solid foods for my infant as s/he is ready for them, and after I have discussed it with child care facility staff. **OR**

☐I will provide solid foods for my infant.

TODDLER FEEDING PREFERENCE (12 THROUGH 23 MONTHS)

Check all that apply: ☐ Spoon ☐ Cup ☐ Feeds Self ☐ Feeding Table or Chair

TYPE OF FOOD	FEEDING TIME	KINDS OF FOOD	AMOUNT OF FOOD
Breastmilk			
Milk			
Table Food			

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity. Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339. To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by: mail:U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410; or fax: (833) 256-1665 or (202) 690-7442; or email: Program.Intake@usda.gov. This institution is an equal opportunity provider.

ARRANGEMENTS FOR SLEEP – Licensing rules require that infants be placed on their back to sleep.

TIME(S) CHILD USUALLY NAPS	LENGTH OF NAP

ADDITIONAL INSTRUCTIONS RELATED TO SLEEPING:

Note: When, in the opinion of the infant's licensed health care provider, an infant requires alternative sleep positions or special sleeping arrangements that differ from those required by rule, the provider must have on file at the facility written instructions, signed by the infant's licensed health care provider, detailing the alternative sleep positions or special sleeping arrangements for such infant.
The caregiver(s) must put the infant to sleep in accordance with such written instructions.

☐ My child is 12 months or older,and I give my permission for my child to sleep on a cot.

SIGNATURE OF PARENT/LEGAL GUARDIAN	DATE

DIAPERING INSTRUCTIONS

LIST ANY LOTIONS AND/OR OINTMENTS, ETC. THAT YOU HAVE PROVIDED AND GIVE PERMISSION FOR CAREGIVERS TO USE ON YOUR CHILD:

FOR ☐WET ☐ BOWEL MOVEMENT ☐RASH ☐ OTHER

☐I do not want caregivers to use any lotions, powders, ointments, or similar items on my child.

I WILL FURNISH THE FOLLOWING BABY SUPPLIES FOR MY CHILD; CLEARLY LABELED WITH MY CHILD'S NAME:

SPECIAL INSTRUCTIONS FOR CARE (E.G., RESTRICTIONS, ALLERGIES, ETC.):

SIGNATURE OF PARENT/LEGAL GUARDIAN	DATE