

February

BLESSED SACRAMENT AFTER CARE

Child's Name/Grade:

Place a check on the days your child will attend the After Care Program for this month. Use the space below to calculate fees. Make checks payable to BS AFTER CARE. Return completed calendar and check to the school office by the end of the first week of each month.

Number of Regular Days:

(3:10-6:15pm) _____ x \$20= _____

Number of Half Days (choose one):

(12:30-3:10pm) _____ x \$20= _____

(12:30-6:15pm) _____ x \$34= _____

TOTAL FOR MONTH: \$ _____

IMPORTANT: If your child will attend a special activity, please specify on this calendar (e.g. Art, 3:15-4:15; Choir, 3:10-4:15).

Note: Late fee for pick-up after 6:15 is one dollar per minute. Please pay the staff person waiting with your child.

NO CREDIT IS GIVEN FOR MISSED DAYS.

MONDAY	TUESDAY	WEDNESDAY	THURSDAY 1) _____	FRIDAY 2) _____
5) _____	6) _____	7) _____	8) _____	9) _____ 12:30 DISMISSAL *BRING LUNCH
12) _____	13) _____	14) _____	15) _____	16) _____
19) <u>X</u> NO SCHOOL	20) _____	21) _____	22) _____	23) _____ 12:30 DISMISSAL *BRING LUNCH
26) _____	27) _____	28) _____		

