

October

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= _____

of late pymts _____ x \$25= _____

TOTAL FOR MONTH: \$ _____

IMPORTANT

*Payments received after the 2nd week of the month will be subject to a \$25.00 late fee.

*If your child will attend a special activity, please specify on this calendar (e.g. Art, Tuesdays, 3:10-4:30; Choir, Thursdays, 3:10-4:30).

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	FRIDAY
	1) _____	2) _____	3) _____	4) _____
7) _____	8) _____	9) _____	10) _____	11) _____ 12:30 DISMISSAL *BRING LUNCH
14) <u> X </u> NO SCHOOL	15) _____	16) _____	17) _____	18) _____
21) _____	22) _____	23) _____	24) _____	25) _____
28) _____	29) _____	30) _____	31) _____	1) <u> X </u> NO SCHOOL
				