

BLESSED SACRAMENT

AFTER CARE

February

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:

(3:10-6pm) _____ x \$30= _____

Number of Half Days (choose one):

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

(12:30-5:00pm) _____ x \$40= _____

TOTAL FOR MONTH: \$ _____

IMPORTANT

For planning purposes, we ask that parents submit monthly calendars by the first week of each month.

Daily drops-in are accepted but will be charged \$35.

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

NO CREDIT IS GIVEN FOR MISSED DAYS.

MONDAY 2) _____	TUESDAY 3) _____	WEDNESDAY 4) _____	THURSDAY 5) _____	FRIDAY 6) _____
9) _____	10) _____	11) _____	12) _____	13) _____ 12:30 Dismissal *Bring Lunch
16) <u>X</u> No School	17) _____	18) _____	19) _____	20) _____
23) _____	24) _____	25) _____	26) _____	27) _____



Questions? salbertson@BSDC.org

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