BLESSED SACRAMENT

AFTER CARE

October

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 $25=_____

Number of Half Days (choose one):

(12:30-3:10pm) ____x $25=_____

(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 $30.

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	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
6) ___	7) ____	8) ____	9) ____	10) ____
13) __X__ **No School**	14) ____	15) ____	16) ____	17) ____ 12:30 Dismissal *Bring Lunch
20) ____	21) ____	22) ____	23) ____	24) ____
27) __X__ **No School**	28) ____	29) ____	30) ____	31) ____ 12:30 Dismissal *Bring Lunch

Questions? salbertson@BSDC.org	Tax ID #: 53 0208375