BEFORE SCHOOL CHILD CARE PROGRAM

Student's Name_____ **Grade** _____ **Teacher's Name**_____

Attendance for the program must be selected in advance and there are NO refunds. Payment should be made by Check and/or Money Orders to the Bayonne Board of Education by the 1st of the month.

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
1 PAYMENT DUE	2	3	4	5
8	9	10	11	12 *LAST DAY ASCC
15	16	17	18 E	19 JUNETEENTH NO SCHOOL
22	23	24	25	26 *LAST DAY OF SCHOOL
29	30			

JUNE 2026

Please indicate with an (X) on the calendar which days your child/children will be attending.

My child will attend *ALL 19 regular scheduled school days:* **TOTAL =** _____

1 Child	2 Children	3+ Children
$190	$304	$399

My child will attend _____ days x $_____ **TOTAL**= _____

1 Child	2 children	3+ children
$10	$16	$21

Parent's signature_____ Date _____