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	2 FIRST DAY OF SCHOOL	3	4
7 NO SCHOOL	8 PAYMENT DUE FIRST DAY OF BEFORECARE	10	11	12
14	15	16	17	18 ABBREVIATED SESSION
21	22	23	24	25
28	29	30		

SEPTEMBER 2026

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

My child will attend *ALL 17 regular scheduled school days:* **TOTAL =** _____

1 Child	2 Children	3+ Children
$170	$272	$357

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

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

Parent's signature_____ Date _____