

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
5	6	7	8	9
12 NO SCHOOL	13	14	15	16
19	20	21	22	23
26	27	28	29	30 ABBREVIATED SESSION

OCTOBER 2026

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

My child will attend *ALL 21 regular scheduled school days*: **TOTAL =** _____

1 Child	2 Children	3+ Children
\$210	\$336	\$441

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

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

Parent's signature _____ Date _____