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
2 PAYMENT DUE	3 NO SCHOOL	4 NO SCHOOL	5 NO SCHOOL	6 NO SCHOOL
9	10	11 NO SCHOOL	12	13
16	17	18	19	20
23	24	25 ABBREVIATED SESSION @ LINCOLN	26 NO SCHOOL	27 NO SCHOOL
30				

NOVEMBER 2026

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

My child will attend *ALL 14 regular scheduled school days:* **TOTAL =** _____

1 Child	2 Children	3+ Children
$140	$224	$294

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

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

Parent's signature_____ Date _____