

# AFTER SCHOOL CARE PRE-REGISTRATION FORM

## City Park Campus

Student's Name: (Please print.) \_\_\_\_\_

Grade: \_\_\_\_\_

Please select one of the following options:

\_\_\_\_\_ **EVERY DAY**

Rate: \$100 per month payable on the first day of the month

\_\_\_\_\_ **CERTAIN DAYS OF THE WEEK**

*Please indicate which day(s) of the week by checking all that apply.*

\_\_\_\_\_ Monday    \_\_\_\_\_ Tuesday    \_\_\_\_\_ Wednesday    \_\_\_\_\_ Thursday    \_\_\_\_\_ Friday

Rate: \$7 per day times the number of days of service payable weekly  
on the first day of the week that the service is used.

\_\_\_\_\_ **RANDOM AS NEEDED**

Rate: \$7 per day payable on the day of service.

Parent's Signature: \_\_\_\_\_

Date: \_\_\_\_\_