

EXTENDED TIME PROGRAM 2011/2012
REGISTRATION FORM

Program Description: Extended time is an after school program offered to St. Thomas the Apostle K-8 students. It provides adult supervision with snacks, homework time and a variety of both indoor and outdoor activities. **Please note: There will be No Extended Time offered on early dismissal days or on days when school is closed.**

Monthly Tuition Rate for 4:15/6:15 pick-up

	1 Child	2 Children	3 Children
2 days/wk	\$80.00/\$115	\$105/\$160	\$130/\$210
3 days/wk	\$95.00/\$145	\$135/\$215	\$170/\$250
4 days/wk	\$115/\$175	\$165/\$260	\$210/\$345
5 days/wk	\$130/\$200	\$185/\$320	\$240/\$420

- Tuition: Bills will be generated a month in advance on the 10th of every month with payment due on the 20th. (Example: October tuition is due September 20).
- Full monthly tuition is expected September through May, There will be no charge in August or June.
- A \$5.00 late fee will be charged for every 15 minutes beyond scheduled pickup time.
- Extra days, when needed, can be added for a \$10.00/\$20.00 fee, per day, per child,

	Child's First Name	Last Name	Grade	Teacher
1.	_____			
2.	_____			
3.	_____			

E.T Days and Times of Attendance

- Please check days of attendance and circle pick-up times 4:15/6:15

Monday __ 4:15/6:15 Tuesday __ 4:15/6:15 Wednesday __ 4:15/6:15

Thursday __ 4:14/6:15 Friday __ 4:15/6:15 **Total Monthly Tuition \$** _____

Parent/Guardian Printed Names _____
Parent/Guardian Signature _____ Date _____

***Please note a nonrefundable processing fee of \$50.00 per family must accompany this completed registration form by August 15, 2011. Save \$15 and pay only \$35.00 per family if it is turned in by June 3, 2011. There are limited spaces available which will be filled on a first come first serve basis.**

**EXTENDED TIME PROGRAM
EMERGENCY/AUTHORIZATION PICK-UP FORM**

Family Name _____ Complete Address _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

Persons to be contacted in case of Emergency

Name	Relationship	Phone #	Cell #

Child/Children's Physician and Phone # _____

Child/Children's Dentist and Phone # _____

Hospital Preference _____

Name of Child(s) Attending	Food Allergies

Please describe any other allergies or conditions:

PERSON AUTHORIZED FOR PICK-UP:

Printed Name	Relationship	Phone #	Cell #

Signature of Parent/Guardian: _____ Date: _____