

AFTER SCHOOL CARE (ASC) Request Form

Week of: _____

Student Name(s): _____

Monday Tuesday Wednesday Thursday Friday

(indicate time of pick-up on each day)

Amount PAID _____

Rates:

3:30 - 4:00 \$4 per child

3:30 - 4:30 \$8 per child

3:30 - 6:00 \$13 for 1st child, \$10 for additional child (not to exceed \$25)

Half Day \$20 for 1st child, \$17 for additional child (not to exceed \$45)

Full Day \$35 for 1st child, \$27 for additional child (not to exceed \$70)

Drop-in \$15 for 1st child, \$12 for each additional child