



DROP-IN CARE PAYMENT AGREEMENT

Child's Name: _____ Drop-In Date: _____

Child's Date of Birth: _____ Child's Age: _____

Parent Name: _____

Parent Address: _____

Parent Phone Number: _____

Emergency Contact Name and Number: _____

Child's Classroom Assignment: _____

Time of Drop-Off: _____ Estimated Time of Pick Up: _____

Actual Time of Pick Up: _____ Total # of Hours at Center: _____

Drop-In Rate is \$10.00 per hour OR the weekly rate for the age of the child divided by 5 days in order to determine the daily rate. We charge whichever amount is less.

***apply 10% sibling and/or 10% military discount if applicable**

Parent/Guardian Signature _____ Date _____

Total Amount Due: _____

Amount Paid: _____ Payment Method: _____

Parent/Guardian Signature _____ Date _____