

NAME OF CHILD: \_\_\_\_\_ D.O.B. \_\_\_\_\_ AGE \_\_\_\_\_

	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
1									
2									
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29									
30									
31									

**\*\* Mark an "X" by the days your child will attend Clarence Center Child Care**

**"PLEASE RETURN THIS FORM WITH A \$25 PROCESSING FEE.**

**"(MADE OUT TO CLARENCE CENTER CHILD CARE, INC).**

**"SIGNATURE OF PARENT: \_\_\_\_\_ DATE: \_\_\_\_\_**

**"FOR OFFICE USE ONLY:**

**"DATE: \_\_\_\_\_ "REGISTRATION FEE: \_\_\_\_\_ "CK#: \_\_\_\_\_**