SR CATHEDRAL OF
Saint Raymond School

Extended Day School (EDS) Program
2023-2024

<u>**EDS HOURS / LOCATIONS**</u>

Morning Program: 7:00AM-7:30 AM
    (students will then be directed to the safety zone where early arrivals are supervised)
Afternoon Program: Dismissal-6:00 PM

<u>Location</u>
Enter at door #10 on Douglas St.

EDS Phone Number: 815-722-6626 x4

<u>**EDS FEES**</u>

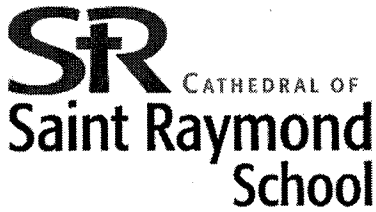| **Morning Program:**	**Afternoon Program:**
Enter at door # 10 on Douglas Ave. between 7:00-7:30	Leave by 4:00 $5.50 + each additional child $2.75
$3.50 + each additional child $2.00	Leave by 5:00 $11.00 + each additional child $5.50
	Leave by 6:00 $15.00 + each additional child $8.00

<u>**AFTERNOON SCHEDULE**</u>

3:00	Sign-in/ Snack and Books
3:30	Outdoor/Gym Time
4:15	Homework/Puzzles/Table Activities/Crafts
5:00	Story time/Book Browsing
5:30	Teacher choice

*Subject to Change

<u>**AFTER SCHOOL CLUBS AND PROGRAMS**</u>

St. Ray's typically partners with a number of organizations to offer a variety of opportunities to students after school. Participants in those programs are not charged the EDS rate. A student is only charged based on the time they enter. Please check the Thursday folder for sign-up sheets to these programs.

Extended Day School (EDS)
Agreement and Authorization Form
2023-2024

CATHEDRAL OF Saint Raymond School

Family Name _____

Child's Name	**Birthdate**	**Grade**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Will you be using EDS in the: _____Morning?   _____Afternoon?

Usual days of attendance:
_____Mon.   _____Tues.   _____Wed.   _____Thurs.   _____Fri.

_____ Will only use on occasion

Estimated time of pick up: _____

The following adults are authorized to pick up my child(ren):
(Students who participate in EDS will only be allowed to leave with the adults listed below. If an adult is not on the list, the student will not be dismissed. They should be prepared to present a picture ID.)

_____   _____
Name/Relation   Name/Relation

_____   _____
Name/Relation   Name/Relation

Do not allow my child/ren to be picked up by: _____

Health Awareness
Please specify medical allergies, chronic illnesses, or other conditions the extended care staff should be aware of and for which child:

_____

_____

Emergency Contact Information

1. Mother's Place of Work: _____ Work Phone # _____

   Cell Phone #_____ Email Address: _____

2. Father's Place of Work: _____ Work Phone # _____

   Cell Phone #_____ Email Address: _____

3. Nearby Relative or Friend of the Family: _____

     Phone # _____

4. Nearby Relative or Friend of the Family: _____

     Phone # _____

PLEASE NOTE:

- Parents must register with ProCare Tuition Express to participate in EDS.
- There is a $35 EDS Registration fee due at the time of registration. Please attach a check to this form.
- EDS bills are emailed to parents through ProCare at the beginning of the month.
- The bill includes charges from the previous month.
- Payments are withdrawn on the 15th of the month.
- All payments are due in full by the last day of the month or your child/children cannot attend EDS.
- Report cards may be held for delinquent accounts.
- EDS has its own phone extension: 815-722-6626 x4. It can be accessed from 3:00 PM until 6:00 PM.

By signing this form, we are aware of the policies and procedures set forth for the Extended Day program, including pricing and billing. We are aware that the Extended Day School (EDS) ends at 6:00 PM. Any late pick-ups will be billed at $1.00 per minute (unless in cases of extreme inclement weather).

_____   _____

Mother's Signature   Date   Father's Signature   Date

Tuition® Express

We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT and CREDIT CARD

I (we) hereby authorize (business name) _____ to initiate credit card charges to the below-referenced credit card account **(Section A)** OR, initiate debit entries to my (our) checking or savings account, indicated below **(Section B).** To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Cardholder Name   Phone #

Cardholder Address   City   State   Zip

Account Number   Expiration Date

Cardholder Signature   Date

SECTION B (Bank Account)

Your Name   Phone #

Address   City   State   Zip

Bank or Credit Union Name   Bank or Credit Union Address   City   State   Zip

Routing Transit Number (see sample below)   Account Number (see sample below)   ☐ Checking   ☐ Savings

Authorized Signature   Date

For Official Use Only

Date Received
Employee Signature

Attach Voided Check Here

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procare
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