CHANGE FORM

Any changes for the <u>current</u> or <u>next school year</u> must be received 30 days in advance to be credited/refunded. <u>Summer Camp</u> changes must be received before June 1st to be credited/refunded. Information changes that affect emergency situations, such as phone numbers are immediate.

DATE:_____ **PROGRAM/CAMP LOCATION:**_____

CHILD'S NAME:_____ **PARENT'S NAME:**_____

REGISTRATION NUMBER:_____

I AM CHANGING THE FOLLOWING INFORMATION: (circle all that apply)

CHILD'S SCHEDULE MEDICAL INFORMATION PARENT INFORMATION

PICKUP INFORMATION PAYMENT INFORMATION

<u>PLEASE MAKE ALL CHANGES IN THE APPROPRIATE CATEGORY:</u>

<u>EFFECTIVE DATE FOR CHANGE:</u>_____

SCHOOL YEAR SCHEDULE INFORMATION IS CHANGING TO: (circle all that apply)

<u>BEFORE SCHOOL</u>	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
<u>AFTER SCHOOL</u>	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
PICKUP TIME (ONLY SELECT ONE)	4:00	5:00	6:00	6:30	
<u>KINDERGARTEN WRAP</u>					
AM SESSION	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
PM SESSION	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY

<u>DROP IN ONLY</u> BEFORE SCHOOL AFTER SCHOOL KINDERGARTEN WRAP

REASON:_____

SUMMER CAMP SCHEDULE INFORMATION IS CHANGING TO: (circle all that apply)

<u>ALL OTHER CAMPS (SEE LEBANON TOWNSHIP BELOW)</u>

WEEK 1	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
WEEK 2	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
WEEK 3	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
WEEK 4	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
WEEK 5	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
WEEK 6	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
WEEK 7	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
WEEK 8	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
WEEK 9	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY

<u>LEBANON TOWNSHIP CAMP ONLY:</u>

WEEK 1	9:00-12:00	7:30-12:00	9:00-5:30	7:30-5:30
WEEK 2	9:00-12:00	7:30-12:00	9:00-5:30	7:30-5:30
WEEK 3	9:00-12:00	7:30-12:00	9:00-5:30	7:30-5:30
WEEK 4	9:00-12:00	7:30-12:00	9:00-5:30	7:30-5:30
WEEK 5	9:00-12:00	7:30-12:00	9:00-5:30	7:30-5:30
WEEK 6	9:00-12:00	7:30-12:00	9:00-5:30	7:30-5:30
WEEK 7	9:00-12:00	7:30-12:00	9:00-5:30	7:30-5:30

REASON:_____

MEDICAL INFORMATION IS CHANGING TO:

INSURANCE POLICY NAME:_____ POLICY NUMBER:_____

PHYSICIAN'S NAME: _____ PHYSICIANS NUMBER: (____)_____

ALLERGY OR MEDICAL INFORMATION:_____

PARENT INFORMATION IS CHANGING TO:

NAME:_____

PHONE NUMBER: (____)_____ OF (PLEASE CIRCLE) HOME WORK CELL

ADDRESS:_____

EMPLOYER NAME:_____POSITION:_____

EMPLOYER ADDRESS:_____

PICKUP INFORMATION IS CHANGING TO:

THIS INFORMATION IS FOR A: (PLEASE CIRCLE) AUTHORIZED PICKUP RESTRICTED PICKUP*

STATUS OF AUTHORIZED PICKUP: (PLEASE CIRCLE) ADD A PICKUP REMOVE A PICKUP UPDATE

1.)NAME:_____ RELATION TO CHILD:_____

HOME PHONE NUMBER: (____)_____CELL PHONE: (____)_____ WORK PHONE: (____)_____

2.)NAME:_____ RELATION TO CHILD:_____

HOME PHONE NUMBER: (____)_____CELL PHONE: (____)_____ WORK PHONE: (____)_____

** IF RESTRICTED PICKUP INVOLVES A BIOLOGICAL PARENT, THAN A COURT ORDER MUST BE PROVIDED BY MAIL OR FAX.*

PAYMENT INFORMATION IS CHANGING TO:

PLEASE UPDATE OUR BILLING ADDRESS OR EMAIL :_____

PLEASE SEND OUR MONTHLY INVOICES: (please circle) EMAIL HOME ADDRESS

WE WOULD LIKE TO SIGN UP FOR AUTOMATIC MONTHLY PAYMENTS: YES NO

- ☐ EZ EFT AUTHORIZATION FROM OUR DEBIT/CHECKING

  ROUTING NUMBER:_____ ACCOUNT NUMBER:_____

- ☐ CREDIT CARD AUTHORIZATION

  CREDIT CARD NUMBER:_____EXPIRATION DATE:_____

  BILLING NAME ON CREDIT CARD:_____

  BILLING ADDRESS OF CREDIT CARD:_____

ADDITIONAL COMMENTS:

_____

_____

_____

SIGNATURE OF PARENT/GUARDIAN DATE

PLEASE MAIL TO WFC P.O. BOX 1155, WHITEHOUSE STATION, NJ 08889 OR FAX (908) 534-5985