# AUTHORIZATION FORM FOR BEFORE/AFTER CARE PROGRAM

**Name of the organization: Resurrection Lutheran School**

**Type of Authorization: ____ New ____Change Banking Info ____Change Amounts (same account)**

**Name: _____**

**Address: _____**

**Email: _____**

**Date of First Before/After Care Program payment: 9/5/2021** **(if student begins after this date, then 5th of following month)**

**Date of Last Before/After Care Program payment: 5/5/2022**

**Frequency of Payment: Monthly on the 5th**

**Before/After Care Program Authorized Monthly Payment: $_____**

**Please debit my payment from:**

**_____ Savings Account**

**_____ Checking Account** **(attach voided check below)**

**Routing Number: _____** **(9 digit number beginning with 0, 1, 2 or 3)**

**Account Number: _____**

**I authorize the above organization to process debit entries to my account. I understand that this authority will remain in effect until I provide reasonable notification to terminate the authorization.**

**Authorized Signature: _____ Date: _____**