The Saklan School
Pre-K Through 8

Extended Care Payment Authorization Form

Student(s) name: ______________________________

I authorize The Saklan School to initiate an automatic withdrawal from the account specified below on or around the 10th of each month for Extended Care expenses. This authorization will remain in effect for the current school year until I cancel it in writing and in such time as to afford The Saklan School a reasonable opportunity to act on it.

Please select complete ONE section and include a voided check, if applicable.

Bank Account:

Name on bank account: ______________________________

Name of bank: ______________________________

Account Type: ☐ Checking ☐ Savings

Bank account number: ______________________________

Bank routing number: ______________________________

Credit Card:

Name on credit card: ______________________________

Card number: ______________________________

Cardholder Address: ______________________________

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Expiration Date: ______________________________

______________________________ ____________________
Signature of Account Holder Date

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