TRINITY
LUTHERAN SCHOOL
CHRIST-CENTERED ACADEMIC EXCELLENCE

ADMISSIONS PACKET

PRESCHOOL

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TRINITY LUTHERAN SCHOOL
CHRIST-CENTERED ACADEMIC EXCELLENCE

Preschool Registration

This letter contains all the information and lists the forms you will need to register your child for preschool. Please fill it out completely, as the Department of Human Services requires that you leave nothing blank.

The forms that require a doctor or dentist appointment should be returned as your child visits the doctor and dentist—preferably this spring and early summer, but definitely in August. **As a state-licensed preschool, we are required to have these forms on file; therefore, please don't plan on sending your child to school if we don't have all the forms needed.**

If you need assistance or have questions about the forms, our school secretary, Rose, works 8:00 to noon on school days and is in the cubicle outside the northwest door of the sanctuary. She can be reached by phone at 432-6912 or e-mail at secretary@tlsboone.us.

Home visits will be scheduled electronically in early August.

The fees for preschool include a book/supply fee paid at the time you register your child and a tuition fee. You may receive a 5% discount on the tuition fee if you pay the tuition in **full by August.** Otherwise, the automatic withdrawal form must be filled out with the first payment scheduled for September.

Three-year-old students may qualify for tuition assistance through BooSt Together for Children Early Childhood Iowa Area Board if your income falls within their guidelines. Applications for this assistance will be available around June 1. Please see Rose about this.

Students who are 4 years old on September 15th will qualify for free tuition through the Boone Schools' participation in the Statewide Voluntary Preschool Program. The form with "Student Information" on one side and "Family Information" on the other side qualifies your student for this program.

Checklist:

- ☐ Preschool Registration Form
- ☐ A copy of student's birth certificate (new students only)
- ☐ Student Information Form (4-year-old students only)
- ☐ Current immunization record
- ☐ Current medical record form (physical) signed by a doctor
- ☐ Iowa KidSight Consent Form
- ☐ PTL Directory Information Form
- ☐ Vision card (optional)
- ☐ Dental screening form (optional)
- ☐ Automatic withdrawal authorization form

Trinity Lutheran School
Preschool Fees

FEES 2023-24

3-Year Olds:

2-day session (Mon, Thurs OR Tues, Fri; 8-11 AM)

2-day session (Tues, Thurs; Noon to 3 PM)

- Book/supply fee - $25 (paid at time of registration)
- Tuition fee - $136.66/mo. ($1,230/yr. OR $1,168.50 with 5% discount) due the 15th of each month beginning Sept. 15 with the final payment on May 15

3-day session (Mon, Wed, Fri; Noon to 3 PM)

- Book/supply fee - $35 (paid at time of registration)
- Tuition fee - $161.66/mo. ($1,455/yr. OR $1,382.25 with 5% discount) due the 15th of each month beginning Sept. 15 with the final payment on May 15

4-Year Olds and 5-Year Olds:

4-day session (Mon, Tues, Thurs, Fri; 8-11 AM)

4-day session (Mon, Tues, Thurs, Fri; Noon to 3 PM)

- Book/supply fee - $50 (paid at time of registration)
- Tuition fee - $196.66/mo. ($1,770/yr. OR $1,681.50 with 5% discount) due the 15th of each month beginning Sept. 15 with the final payment on May 15 (**no tuition collected for 4-year olds if government grant is still in place)**

Optional Wednesday afternoon class, Noon to 3 PM

- Additional $15 per day

Please note: *If full tuition is paid by August 25th, a 5% discount is allowed. Families who do not pay in full will do electronic funds transfers from checking or savings accounts.*

TRINITY LUTHERAN SCHOOL
CHRIST-CENTERED ACADEMIC EXCELLENCE

Preschool Supply List

3-Year Olds:

*Backpack—standard size
*1 pocket folder
*24-count box of **Crayola** crayons
*Box of markers (broad line)
*Scissors (**Fiskars** makes good kid-friendly scissors that are easy to use)
*Water bottle
*1 complete change of clothes (Please put the change of clothes in a labeled plastic bag in student's backpack)
Set of watercolor paints (**Prang/Crayola** brand is best)
1 bottle of **Elmer's** white glue
2 glue sticks
1 pkg. paper cups (**5 oz.**)
1 pkg. baby wipes
1 box facial tissues
1 roll paper towels
1 box quart-size baggies

4-Year Olds:

*Backpack—standard size
*1 pocket folder
*24-count box of **Crayola** crayons
*Box of markers (broad line)
*Scissors (**Fiskars** makes good kid-friendly scissors that are easy to use)
*Water bottle
*1 complete change of clothes (Please put the change of clothes in a labeled plastic bag in student's backpack)
Set of watercolor paints (**Prang/Crayola** brand is best)
1 bottle of **Elmer's** white glue
2 glue sticks
1 container of **Clorox Wipes/Anywhere Spray**
1 pkg. of napkins
1 box facial tissues
1 box plastic spoons

3 Year Old Preschool
Trinity Lutheran School

712 12th Street • Boone, IA 50036

For those who are 3 years old on or before September 15, 2023. Mark N/A if nothing applies.

Class: ☐ 2-day AM (M, Th) ☐ 2-day AM (T, F) ☐ 2-day PM (T, Th) ☐ 3-day PM (M, W, F)

Child's Name (first-middle-last) _____

Child prefers to be called _____

Gender: ☐ M ☐ F Birth Date _____ Baptism Date _____

Child's Primary Address _____

Before/After School Care Provider_____ Phone _____

Family Status: ☐ Single Parent ☐ Two Parent ☐ Two Parent - Remarried

Mother's Name_____ Phone _____

Permission to add Mother's number to "Remind" to receive texts from school ☐ Yes ☐ No

Address_____

E-mail Address_____ Church You Attend _____

Employer _____ Work Phone _____

Father's Name_____ Phone _____

Permission to add Father's number to "Remind" to receive texts from school ☐ Yes ☐ No

Address _____

E-mail Address _____ Church You Attend _____

Employer_____ Work Phone _____

Siblings' Names_____

Emergency Information:

☐ Yes ☐ No I hereby give my permission and/or consent to the personnel of Trinity Lutheran Preschool to secure and authorize such emergency medical or dental care and/or treatment as my child might require while under the supervision of said preschool personnel. I also agree to pay all of the costs and fees contingent on any emergency medical or dental and/or treatment for my child as secured or authorized under this consent. (Every effort will be made to notify parents immediately in case of emergency.)

Doctor/Clinic Name_____ Phone _____

Doctor/Clinic Address _____ Hospital _____

Dentist Name _____ Phone _____

Dentist Address _____

In an emergency, please call: (in case parents are unreachable)

Name/Relation _____ Phone _____

Name/Relation _____ Phone _____

Field Trips, Picture and Pick-Up Permission — Please check yes or no for the following:

☐ Yes ☐ No I hereby give permission for my child to leave the center for field trips set up by the Trinity Lutheran Preschool teacher in cars driven by volunteer parents or on foot.

☐ Yes ☐ No I hereby give my consent to let my child be photographed for use by Trinity Lutheran Preschool in newspapers or other media for the purpose of publicity or advertisements.

☐ Yes ☐ No I hereby give permission for the following persons named below to pick my child up from preschool. **It is the responsibility of parents to notify Trinity Lutheran Preschool, in writing, of any changes.**

Name/Relation _____ Phone _____

Name/Relation _____ Phone _____

Name/Relation _____ Phone _____

Name/Relation _____ Phone _____

Name/Relation _____ Phone _____

Name of persons who **may not** pick up my child:_____

Separation, divorce, or other custody situations Trinity Lutheran Preschool should be aware of:

_____

_____

Please list any medical allergies, medications being taken, medical problems, etc.:

_____

_____

Please list any other pertinent information the teacher should know regarding your child:

_____

_____

_____ _____

Parent/Guardian Signature Date

4 Year Old Preschool
Trinity Lutheran School

712 12th Street • Boone, IA 50036

For those who are 4 years old on or before September 15, 2023. Mark N/A if nothing applies.

Class: ☐ 4-day AM (M, T, Th, F) ☐ 4-day PM (M, T, Th, F) ☐ Wed PM (optional for an additional fee)

Child's Name (first-middle-last) _____

Child prefers to be called _____

Gender: ☐ M ☐ F Birth Date _____ Baptism Date _____

Child's Primary Address _____

Before/After School Care Provider_____ Phone _____

Family Status: ☐ Single Parent ☐ Two Parent ☐ Two Parent - Remarried

Mother's Name_____ Phone _____

Permission to add Mother's number to "Remind" to receive texts from school ☐ Yes ☐ No

Address_____

E-mail Address_____ Church You Attend _____

Employer _____ Work Phone _____

Father's Name_____ Phone _____

Permission to add Father's number to "Remind" to receive texts from school ☐ Yes ☐ No

Address _____

E-mail Address _____ Church You Attend _____

Employer_____ Work Phone _____

Siblings' Names_____

Emergency Information:

☐ Yes ☐ No I hereby give my permission and/or consent to the personnel of Trinity Lutheran Preschool to secure and authorize such emergency medical or dental care and/or treatment as my child might require while under the supervision of said preschool personnel. I also agree to pay all of the costs and fees contingent on any emergency medical or dental and/or treatment for my child as secured or authorized under this consent. (Every effort will be made to notify parents immediately in case of emergency.)

Doctor/Clinic Name_____ Phone _____

Doctor/Clinic Address _____ Hospital _____

Dentist Name _____ Phone _____

Dentist Address _____

In an emergency, please call: (in case parents are unreachable)

Name/Relation _____ Phone _____

Name/Relation _____ Phone _____

Field Trips, Picture and Pick-Up Permission — Please check yes or no for the following:

☐ Yes ☐ No I hereby give permission for my child to leave the center for field trips set up by the Trinity Lutheran Preschool teacher in cars driven by volunteer parents or on foot.

☐ Yes ☐ No I hereby give my consent to let my child be photographed for use by Trinity Lutheran Preschool in newspapers or other media for the purpose of publicity or advertisements.

☐ Yes ☐ No I hereby give permission for the following persons named below to pick my child up from preschool. **It is the responsibility of parents to notify Trinity Lutheran Preschool, in writing, of any changes.**

Name/Relation _____ Phone _____

Name/Relation _____ Phone _____

Name/Relation _____ Phone _____

Name/Relation _____ Phone _____

Name/Relation _____ Phone _____

Name of persons who **may not** pick up my child:_____

Separation, divorce, or other custody situations Trinity Lutheran Preschool should be aware of:

_____

_____

Please list any medical allergies, medications being taken, medical problems, etc.:

_____

_____

Please list any other pertinent information the teacher should know regarding your child:

_____

_____

_____ _____

Parent/Guardian Signature Date

STUDENT INFORMATION

Student Name _____ Commonly goes by _____
(Legal last name, First, Middle)

Date of Birth _____ Sex : M☐ F☐ Grade _____ For School Year _____

Is this student a previous Boone Community School's student? Y☐ N☐ Is this student a foster child? Y☐ N☐

Student's Cell Phone (optional) _____ Student's Main Language Spoken _____

Birth Country _____ Date Entered US _____ First Date Entered US School _____
(if not USA)

Foreign Exchange Student? Y☐ N☐ Foreign Student on Visa? Y☐ N☐

Special Education (IEP)? Y☐ N☐ 504 Plan? Y☐ N☐ ELL Program? Y☐ N☐

Field Trip Permission? Y☐ N☐ Oldest child in the household attending BCSD? Y☐ N☐

FEDERALLY REQUIRED ETHNICITY INFORMATION

Is this student Hispanic/Latino? (Spanish culture/origin, regardless of race) Y☐ N☐

*Student Race: (check all that apply) If no boxes are marked then white is default.

American Indian or Alaska Native☐ Black or African American☐ White☐ Asian☐ Native Hawaiian or Pacific Islander☐

FOR STUDENTS ENTERING KINDERGARTEN
Attended Preschool? Y☐ N☐

Name of Preschool _____

FOR NEW STUDENTS ENTERING BCSD AFTER STARTING 9th GRADE

Year Started 9th Grade _____

Birth Verification (required to view or have copy - this can be a birth certificate, passport, hospital record or other approved format) _____

Is there a court order regarding custody for this student? Y☐ N☐ If yes, please provide a copy to be sent to the school.

If Emergency/Contact/Relationships are the same for ALL students/children, please check here: ☐

Emergency Contact	Relationship	Home Phone	Work Phone	Cell Phone
	Doctor	N/A		N/A
	Dentist	N/A		N/A
	Daycare Provider	N/A		N/A

By signing below, I certify that all information entered is accurate and correct.

_____

Parent/Guardian Signature Date

(Over Please)

FAMILY INFORMATION

PRIMARY HOUSEHOLD Should be a Boone Community School District street address where the students(s) live (unless open enrolled).

Address _____ Phone _____ Unlisted Y☐ N☐

City _____ State _____ Zip _____ County _____

Is the above your mailing address? If not, please list mailing address below.

Addess _____ City _____ State _____ Zip _____

Parent/Guardians who live at primary address above

Name _____ Name _____

Relation to Student(s) _____ Relation to Student(s) _____

Main Language Spoken _____ Main Language Spoken _____

Employer _____ Employer _____

Work Phone_____ Cell Phone _____ Work Phone_____ Cell Phone _____

E-Mail _____ E-Mail _____

SECONDARY HOUSEHOLD Additional legal guardians who do not live at primary household.

Address _____ Phone _____ Unlisted Y☐ N☐

City _____ State _____ Zip _____ County _____

Parent/Guardians who live at secondary address above

Name _____ Name _____

Relation to Student(s) _____ Relation to Student(s) _____

Main Language Spoken _____ Main Language Spoken _____

Employer _____ Employer _____

Work Phone_____ Cell Phone _____ Work Phone_____ Cell Phone _____

E-Mail _____ E-Mail _____

Should school mailings also be sent to this secondary household? Y☐ N☐

Iowa Department of Public Health
Certificate of Immunization

Name Last: _____ First: _____ Middle: _____ Date of Birth: _____

Parent/Guardian: _____ Address: _____ Phone: (___)_____

I certify that the above named applicant has a record of age-appropriate immunizations that meet the requirement for licensed child care or school enrollment.

Signature: _____ Date: _____
Physician, Physician Assistant, Nurse, or Certified Medical Assistant

A representative of the local Board of Health or Iowa Department of Public Health may review this certificate for survey purposes.

	Vaccine	Date Given	Doctor / Clinic / Source
Diphtheria, Tetanus, Pertussis DTaP/DTP/DT/ Td/Tdap			
Polio IPV/OPV			
Measles, Mumps, Rubella MMR			
***Haemophilus influenzae* type b** Hib			
Hepatitis B			

	Vaccine	Date Given	Doctor / Clinic / Source
Varicella Chicken Pox If patient has a history of natural disease write "Immune to Varicella"			
Pneumococcal PCV/PPV			
Meningococcal MCV4/MPSV4			
Hepatitis A			
Rotavirus			
Human Papilloma Virus HPV			
Other			

January 2013

Trinity Lutheran School

Medical Record Form – to be completed by a physician

Student's Name:	Birthdate: Male / Female
Parent's Name:	Parent's phone number:

	Yes/No	Date	Comments		Yes/No	Date	Comments
Allergy to Food				Diabetes			
Allergy to Medicine				Freq. Ear Infections			
Other Allergies				Meningitis			
Asthma				Mono			
Bleeding Problems				Seizures			
Cancer				Surgery			
Cardiac Problems				Throat Infections			
Chicken Pox				Tuberculosis			
Concussion				Other			

Immunizations: Please attach *Iowa Department of Public Health Certificate of Immunization* or an exemption form or other medical records of immunizations. Please check appropriate box below.

- ▫ This patient is up-to-date on immunizations as recommended by ACIP
- ▫ This patient is not up-to-date on immunizations, and will be on a catch-up schedule for: _____
- ▫ This patient has a medical exemption. Please explain: _____

Height	Weight	Blood pressure	Hemoglobin	Lead Screen*	Vision (right)	Vision (left)	Hearing
			Normal/Abnormal	Normal/Abnormal	Corrected/Uncorrected	Corrected/Uncorrected	

* In Iowa, legislation requires all children entering kindergarten have at least one blood lead test. Iowa Code: Chapter.641.67

	Normal	Abnormal	Comments (required for abnormal)
Skin			
Hair and scalp			
Eyes			
Ears			
Nose/ mouth/ dental			
Lymph nodes			
Cardiovascular			
Respiratory			
Gastrointestinal			
Genito-urinary			
Neurological			
Musculoskeletal			
Endocrine			
Nutritional Status			
General Appearance			
Developmental			
Other			

Prescribed medications: _____

_____ Child may participate in developmentally appropriate activities with NO health-related restrictions

_____ Child may participate in developmentally appropriate activities with the following restrictions: _____

Providers signature: _____ Date:_____ Provider printed name: _____

University of Iowa Children's Hospital
University of Iowa Health Care

Iowa KidSight Consent Form

Date of Screening: _____

Is this child currently seeing an eye doctor? ☐ **No** ☐ **Yes, name of eye doctor/clinic:**
_____ **City** _____

If yes, the screening is not necessary and may not be conducted in order to use our limited resources for children whose vision problems have not been identified.

Free vision screening will be offered to children by a local Lions Club. Screenings are in conjunction with Iowa KidSight, in the Department of Ophthalmology and Visual Sciences at University of Iowa Children's Hospital. Vision screening produces images of a child's eyes to determine the presence of eye disorders including far- and near-sightedness, astigmatism, anisometropia (unequal refractive power), strabismus, (misaligned eyes), and media opacities (e.g., cataracts). No physical contact is made with a child and no eye drops are used during the vision screening. This screening is approximately 85-90% effective in detecting problems that can cause reduced vision.

Participation is voluntary. This screening is designed for pre-school-aged children. Children who are younger than 6-months old will not be screened. No child will be screened without a signed and completed consent form. Each individual child needs his/her own consent form. If you have questions, please contact: Iowa KidSight, 2431 Coral Court #5, Coralville, Iowa 52241, or 319-353-7616, or kidsight@uiowa.edu.

Please print or type the information below:

Child's Name _____ (_____)
First Middle Last Initials

Male _____ **Female** _____ **Child's Date of Birth** _____/_____/_____ **Child's Age** _____
(MM/DD/YYYY)

Parent's Name _____

Address _____ **City** _____ **Zip** _____

Home Phone (_____)_____ **Work Phone** (_____)_____

Cell Phone (_____)_____ **E-mail address** _____

I, the undersigned, hereby give permission for my child, _____, to participate in the screening event. I understand the following regarding this program:

1. The information obtained from this screening is preliminary only and does not constitute a diagnosis of vision problems.
2. I will be contacted with the results of the screening through Iowa KidSight at University of Iowa Children's Hospital, or through my child care provider who aided in arranging the screening. I may be contacted regarding follow-up for vision referral by Iowa KidSight staff at University of Iowa Children's Hospital.
3. This screening result may satisfy the requirement for vision screening upon entry to kindergarten, and may be recorded in the Iowa Immunization Registry.
4. I am responsible for arranging a full eye examination with a doctor of my choosing if my child has been referred as a result of the vision screening. Iowa KidSight recommends a dilated eye examination.
5. The results of your child's eye examination will be shared with Iowa KidSight as a means to help evaluate the screening program's effectiveness.
6. Iowa KidSight will maintain the confidentiality of all records and results.
7. I will not hold the Lions Club and its volunteers, Lions Clubs organizations, University of Iowa Children's Hospital, or affiliates, accountable for any errors of commission, omission or other misdiagnosis. There are no foreseeable risks to participating in the Iowa KidSight vision screening.

_____ _____
Signature of Parent or Guardian Date

Revised 8-2015

PTL Directory Information Form

In order to update the PTL Directory, we need the following information. Please fill out completely and return.

Parent(s) Name(s) _____

_____

Address _____

_____

Phone Number _____

_____

Email Address _____

_____

Please include the names and ages of **all** your children (school age or younger) in your family whether they attend Trinity or not.

Child's Name Grade (or age if not yet in kindergarten)

_____

_____

_____

_____

_____

_____

STUDENT VISION CARD

Student First/Last Name _____ Exam Date _____

Student Date of Birth ____/____/____ Student Home Zip Code _____

TO THE PARENT OR GUARDIAN: To fully assess the health of your child's visual system and prevent future learning problems associated with undetected vision problems, regular professional eye exams are essential. Experts estimate that 80% of learning is obtained through vision. Good vision directly contributes to a child's ability to learn while in school. As a part of your back-to-school preparations, it is recommended that you take your child and this card to your family eye doctor for a complete eye health examination. **This card should be signed by the eye care professional and returned to the school nurse or teacher by your child.**

The following organizations recommend the use of the Student Vision Card

IDPH

Iowa Optometric Association

Iowa PTA

Prevent Blindness Iowa

To order more cards call 1-800-444-1772 • www.iowaoptometry.org

Visual Acuity	**At Distance**		**At Near**	
☐ Without correction	R20/	L20/	R20/	L20/
☐ With present correction	R20/	L20/	R20/	L20/
☐ With new correction	R20/	L20/	R20/	L20/

External Eye Health ☐ Normal ☐ Other

Internal Eye Health ☐ Normal ☐ Other

Vision Analysis

R	L		
☐	☐	Normal eyesight	☐ Eye teaming difficulty
☐	☐	Nearsighted (myopia)	☐ Crossed-eyes (strabismus)
☐	☐	Farsighted (hyperopia)	☐ Eye focusing difficulty
☐	☐	Astigmatism	☐ Sensitivity to light
☐	☐	Amblyopia	

☐ Other _____

Vision Correction Recommendations

☐ No correction necessary
☐ No change in present prescription
☐ New prescription needed

To be worn for:
☐ Constant wear ☐ Near vision only
☐ Distance vision only ☐ As needed

TO THE EYE CARE PROFESSIONAL: Please sign and date this card after examination.

Dr. Name: (Please Print) _____

Date _____ Signature _____

11/13

Iowa Department of Public Health
CERTIFICATE OF DENTAL SCREENING

This certificate is not valid unless all fields are complete.
RETURN COMPLETED FORM TO CHILD'S SCHOOL.

Student Information (please print)

Student Last Name:	Student First Name:	Birth Date (M/D/YYYY):
Parent or Guardian Name:	Telephone (home or mobile):	
Street Address:	City:	County:
Name of Elementary or High School:	Grade Level:	Gender: ☐ Male ☐ Female

Screening Information (health care provider must complete this section)

Date of Dental Screening: _____

Treatment Needs (check ONE only based on screening results, prior to treatment services provided):

☐ **No Obvious Problems** – the child's hard and soft tissues appear to be visually healthy and there is no apparent reason for the child to be seen before the next routine dental checkup.

☐ **Requires Dental Care** – tooth decay[1] or a white spot lesion[2] is suspected in one or more teeth, or gum infection[3] is suspected.

☐ **Requires Urgent Dental Care** – obvious tooth decay[1] is present in one or more teeth, there is evidence of injury or severe infection, or the child is experiencing pain.

[1] Tooth decay: A visible cavity or hole in a tooth with brown or black coloration, or a retained root.
[2] White spot lesion: A demineralized area of a tooth, usually appearing as a chalky, white spot or white line near the gumline. A white spot lesion is considered an early indicator of tooth decay, especially in primary (baby) teeth.
[3] Gum infection: Gum (gingival) tissue is red, bleeding, or swollen.

Screening Provider (check ONE only):
☐ DDS/DMD ☐ RDH ☐ MD/DO ☐ PA ☐ RN/ARNP (High school screen must be provided by DDS/DMD or RDH)

Provider Name: (please print) _____ Phone: _____

Provider Business Address: _____

Signature and Credentials of Provider or Recorder*: _____ Date: _____

*Recorder: An authorized provider (DDS/DMD, RDH, MD/DO, PA, or RN/ARNP) may transfer information onto this form from another health document. The other health document should be attached to this form.

A screening does not replace an exam by a dentist.
Children should have a complete examination by a dentist at least once a year.
RETURN COMPLETED FORM TO CHILD'S SCHOOL.

Iowa Department of Public Health • Oral Health Center
515-242-6383 • 866-528-4020 • http://idph.iowa.gov/ohds/oral-health-center
A designee of the local board of health or Iowa Department of Public Health may review this certificate for survey purposes.

Automatic Withdrawal Form

Joyful Response® Electronic Offering Program

Enrollment/Change Form

Complete this form and return it to the church office to begin or change your current stewardship offering. Your offering will be made automatically from your bank account or your LCEF StewardAccount®.

Check the appropriate box:

❑ New enrollment ❑ Offering change ❑ Account information change

Please Print in Black Ink

Member Last Name	First Name	MI	Daytime Telephone
Mailing Address	City, State, ZIP		Email Address
Congregation Name			Congregation Telephone Number
Congregation Mailing Address	City, State, ZIP		

My Offering

Fund Designations:	Amount:
1. General Fund	$
2. Building	$
3.	$
4.	$
5.	$
6.	$
	TOTAL $

Debiting Account

Debit from:

❑ Checking
❑ Savings
❑ LCEF StewardAccount

Account Number

Routing Number *(First nine numbers in bottom left-hand corner of check)*

Transfer Date *(check one)*:

❑ Weekly *(Monday)*
❑ Semi-monthly *(1st and 15th)*
❑ Monthly on the 1st
❑ Monthly on the 15th
❑ Other _____
(As approved by church office.)

Start date: ____/____/____
End date *(if any)*: ____/____/____

Authorization

I authorize the above-named organization and Vanco Services, LLC to process debit entries from my account. This authority will remain in effect until I give reasonable notification to terminate this authorization or until the last specified payment date.

Authorized Signature for Account Date

TO BE COMPLETED BY CHURCH OFFICE

Member ID# _____ Initials _____
Vanco Client ID# _____ Date _____

Attach void check or savings deposit slip here.

S00490 201311