

Date Received by MC3

Child Care Attendance Record

MC3 Use Only

Marin Child Care Council
555 Northgate Dr. #105, San Rafael, CA 94903
415.472.1092

Month _____ Year _____

Child's Name: _____

Child Care Provider: _____

Date of Birth: _____

Address: _____

Parent's Name: _____

City/State/zip: _____

Phone: _____

Type of Care (circle one) Center Licensed Family CC Exempt (friend/relative)

Actual in and out times must be indicated below each day (do not pre-fill schedule). Please make sure forms are complete and accurate BEFORE submitting. Attendance Records are due by the 5th of the month following care. We must receive originals, not copies or faxes. Each day the child does not use care as scheduled, please indicate the reason for the absence (ie: parent/child sick, medical appt., family vacation, provider closed). Providers must notify MC3 after 3 consecutive unexcused absences (when parent has not notified provider with reason).

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Weekly Total
____ to ____ ____ to ____	____ to ____ ____ to ____	____ to ____ ____ to ____	____ to ____ ____ to ____	____ to ____ ____ to ____	____ to ____ ____ to ____	____ to ____ ____ to ____	_____
____ to ____ ____ to ____	____ to ____ ____ to ____	____ to ____ ____ to ____	____ to ____ ____ to ____	____ to ____ ____ to ____	____ to ____ ____ to ____	____ to ____ ____ to ____	_____
____ to ____ ____ to ____	____ to ____ ____ to ____	____ to ____ ____ to ____	____ to ____ ____ to ____	____ to ____ ____ to ____	____ to ____ ____ to ____	____ to ____ ____ to ____	_____
____ to ____ ____ to ____	____ to ____ ____ to ____	____ to ____ ____ to ____	____ to ____ ____ to ____	____ to ____ ____ to ____	____ to ____ ____ to ____	____ to ____ ____ to ____	_____
____ to ____ ____ to ____	____ to ____ ____ to ____	____ to ____ ____ to ____	____ to ____ ____ to ____	____ to ____ ____ to ____	____ to ____ ____ to ____	____ to ____ ____ to ____	_____
____ to ____ ____ to ____	____ to ____ ____ to ____	____ to ____ ____ to ____	____ to ____ ____ to ____	____ to ____ ____ to ____	____ to ____ ____ to ____	____ to ____ ____ to ____	_____

Full signatures are required below. Parent and Provider must sign this section of the Attendance Record on or after the last day of care provided during the month or it will be considered incomplete.

I, (parent/provider) declare under penalty of perjury under the laws of the United States and the state of California that the facts contained in this Attendance Record are true, correct and complete and that the provider named on this form provided the child care.

Parent Signature _____

Date _____

Provider Signature _____

Date _____

Total billed by provider:
Please indicate amount due or attach invoice
Amount due for this month: _____

- Full Time Monthly Rate \$ _____ /month
- Full Time Weekly Rate \$ _____ [X] _____ # of wks \$ _____
- Daily Rate \$ _____ [X] _____ # of days \$ _____
- Part Time Monthly Rate \$ _____ / month
- Part Time Weekly Rate \$ _____ / [X] _____ # of wks \$ _____
- Hourly Rate \$ _____ [X] _____ # of hours \$ _____

Adjustment Factor _____ Comments: _____

CM: _____

Total Due to Provider _____ Family Fee _____ Total to be paid by MC3 _____