

DAY CARE RECEIPT



Child Care Provider \_\_\_\_\_  
SSN or Tax ID # of Day Care Provider \_\_\_\_\_  
Name of Dependent \_\_\_\_\_  
Date of Care: From \_\_\_\_\_ To \_\_\_\_\_  
Amount Paid \_\_\_\_\_ Date Paid \_\_\_\_\_

\_\_\_\_\_  
Authorized Signature of Care Provider

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