Request to Use Sick or Vacation Time

(Request for Vacation Time **MUST** be submitted two weeks prior to vacation date)

Date of Request_____

Child(ren) Name (s)_____

Date(s) of Time Requested Off_____

Reason for Time Off

Sick **Vacation**

Program/Teacher Approval_____

Director Approval_____

Approval Date_____

Please credit my account and adjust my records accordingly.

Parent Signature_____ **Date** _____

Little Learners Children's Center

130 Gallup Hill Rd, Ledyard, CT 06339

Phone 860-572-4411

Fax 860-245-0287