For Office Use Only
Date Received: _______________
Date Recorded: _______________
Amount paid: _______________
FACTS: ____ Check Number: _____

Fatima After-School Care Service
Application Form 2021-2022

Application Fee ($25.00) per family will be drawn from your FACTS account.

Please indicate how often your child will attend:

____Full-time (attends on a regular basis)
____Part-time (3 days per week)
____Part-time (2 days per week)
____Part-time (1 day per week)
____Drop-in

Child's Home Address: ____________________________ City: __________________________ Zip: ___________

Mother's name: ________________________________ Email: ____
Home Number: ________________ Work Number: ______________ Cell Number: _______________

Father's name: ________________________________ Email: ____
Home Number: ________________ Work Number: ______________ Cell Number: _______________
Father's address (if different): ____________________________ City: ___________________ Zip: ____________

Please list your children attending ASC from YOUNGEST to OLDEST

1st Child's Name: ________________________
Grade (2020-21): _____ Grade (2021-22): _____
Birthday: _______________ Current Age: ______

2nd Child's Name: ________________________
Grade (2020-21): _____ Grade (2021-22): _____
Birthday: _______________ Current Age: ______

3rd Child's Name: ________________________
Grade (2020-21): _____ Grade (2021-22): _____
Birthday: _______________ Current Age: ______

4th Child's Name: ________________________
Grade (2020-21): _____ Grade (2021-22): _____
Birthday: _______________ Current Age: ______

Person other than parents to call in an emergency:
Name: ____ Relationship to Child: _____________________
Home Number: _______________ Work Number: ______________ Cell Number: _______________

Medical information:
Physician's Name: ______________________________ Phone Number: _____________________
Hospital Choice: _________________________

On the back of the form, please specify & explain if your child is on any medication or if he/she has a medical condition of which we need to be aware.

1st Child: (Name) _____________________________ Allergies: ____Yes ____No
Explain: ____

2nd Child: (Name) _____________________________ Allergies: ____Yes ____No
Explain: ____

3rd Child: (Name) _____________________________Allergies: ____Yes ____No
Explain: ____

4th Child: (Name) _____________________________ Allergies: ____Yes ____No
Explain: ____

In case of an accident or illness of my child, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated above and to follow his/her instructions. If it is impossible to contact this physician, the school may make whatever arrangements they deem necessary.

____ ____________________
Signature Date

Who has permission to pick up your child? (Please list all people, other than parents, who may pick up your child(ren). (Use the back of this form, if needed.)

Name: _______________________
Relationship to Child: ____________
Phone Number: _________________

Name: _______________________
Relationship to Child: ____________
Phone Number: _________________

Name: _______________________
Relationship to Child: ____________
Phone Number: _________________