For Office Use Only
Date Received: _____
Date Recorded: _____
Amount paid: $50 FACTS: ✓

Fatima After-School Care Service Registration Form 2025-2026

Application Fee **($50.00)** per family **will be drawn from your FACTS account**.

Please indicate how often your child will attend:

☐ Full-time (5 days/week) ☐ Football/Volleyball Season (Players only: gr. 5-8)
☐ Part-time ☐ Fatima Teacher's child

Email completed registration form to Judi Lucito jlucito@olf.org

Please list your children attending ASC from **YOUNGEST to OLDEST**

1st Child's First/Last Name: _____
Grade (2024-25):_____ Grade (2025-26): _____
Current Age: _____ Birthday:_____

3rd Child's First/Last Name: _____
Grade (2024-25):_____ Grade (2025-26): _____
Current Age: _____ Birthday:_____

2nd Child's First/Last Name: _____
Grade (2024-25):_____ Grade (2025-26): _____
Current Age: _____ Birthday:_____

4th Child's First/Last Name: _____
Grade (2024-25):_____ Grade (2025-26): _____
Current Age: _____ Birthday:_____

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: _____

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 with 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: _____