



# AMERICAN OVERSEAS SCHOOL OF ROME

Attach  
Current  
Photo

## Application for Admission Grades Pre-K - Kindergarten

A) <b>CANDIDATE INFORMATION</b> (Please print)			
<b>First Name</b>	<b>Middle Name</b>	<b>Last Name</b>	
<b>Applying for grade</b> _____	School year ____ / ____	Semester I <input type="checkbox"/>	Semester II <input type="checkbox"/>
Or expected Entry Date _____			
Date of birth ____/____/____ <small>Day Month Year</small>	Age	Male <input type="checkbox"/>	Female <input type="checkbox"/>
Country of birth	Citizenship 1	Citizenship 2	
Languages	First Language	Language used at home	Other Languages spoken
Student			
Father			
Mother			

Applicants must be the following ages by Oct. 31 in the year they are entering the grade level:  
*3 years old for PreK3 – 4 years old for PreK4 – 5 years old for Kindergarten*  
**Child must be toilet trained to enter all grade levels.**

<b>Current School Information</b>		
<b>Current school name</b>		<b>Current Grade</b>
Primary language of instruction		Grades attended
School address		
City	State	Zip
Country	Telephone	Email
School Head/Director (Name & Title)		

<b>Previous schools (Most recent at the top)</b>				
School Name	City	Year(s)	Grades completed	Language of Instruction

<b>Learning Support (Mandatory)</b>	
Check if the applicant has received or is receiving support for any physical, emotional, or learning difficulty	
ESL <input type="checkbox"/>	ADD/ADHD <input type="checkbox"/> Speech <input type="checkbox"/> Learning disability <input type="checkbox"/>
IEP <input type="checkbox"/>	Counseling <input type="checkbox"/> Reading <input type="checkbox"/> Under care of psychologist/psychiatrist <input type="checkbox"/>
No support received <input type="checkbox"/>	If <b>Yes</b> to any of the above, please provide a copy of any reports to AOSR.
Please explain partial years of schooling, skipped or repeated grades and home schooling:	
Has the applicant ever been subject to major disciplinary action (suspension or dismissal) in any school? If so, please explain.	



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B)	<b>FAMILY INFORMATION (One per Family)</b>	
Father		Mother
	First Name	
	Last Name	
	Address	
	City/Country	
	State/Zip	
	Home E-mail address	
	Home phone	
	Mobile phone	
	Work phone	

**Is this your contact address?** Yes  No  **Until:** \_\_\_\_\_

**Contact address after this date:** \_\_\_\_\_

**E-mail to be used for school communications:** \_\_\_\_\_  
*Primary e-mail* *Secondary e-mail*

	<b>Employment</b>	
Father		Mother
	Company name	
	Title	
	Position	
	City/Zip/Country	
	Work E-mail	
<input type="checkbox"/> U.S. OR U.S. Affiliated company <input type="checkbox"/> U.N. and U.N. Agencies <input type="checkbox"/> Government Affiliation	Affiliation	<input type="checkbox"/> U.S. OR U.S. Affiliated company <input type="checkbox"/> U.N. and U.N. Agencies <input type="checkbox"/> Government Affiliation

**For U.S. Embassy, please specify department/agency/service** \_\_\_\_\_

<b>Family Status</b>	
<b>Parents marital status:</b> <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Widow/er	
Father remarried Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes", name of spouse: _____	Mother remarried Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes", name of spouse: _____
<b>Applicant lives with</b> If "Other", please specify: <input type="checkbox"/> Both Parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other	
<b>If divorced, who has legal custody?</b> Please provide relevant documentation <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other	
<b>Siblings at (or applying to) AOSR</b>	
1. _____ <span style="margin-left: 100px;"><i>Name</i></span> <span style="margin-left: 100px;"><i>Grade</i></span>	2. _____ <span style="margin-left: 100px;"><i>Name</i></span> <span style="margin-left: 100px;"><i>Grade</i></span>
3. _____ <span style="margin-left: 100px;"><i>Name</i></span> <span style="margin-left: 100px;"><i>Grade</i></span>	4. _____ <span style="margin-left: 100px;"><i>Name</i></span> <span style="margin-left: 100px;"><i>Grade</i></span>



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## Parent Questions

Are you an alumnus/a of AOSR?  Yes  No

If yes, what year(s) did you attend AOSR or graduate?

How did you hear about AOSR?

How long do you plan to stay at AOSR?

What are your reasons for applying to AOSR?

We welcome any additional comments which you might like to make about your child.  
A parental perspective helps. Please feel free to attach additional pages if needed.



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## C) **BILLING INFORMATION** (One per family)

Registration and Capital Assessment fees are payable at the time of initial enrollment and are not refundable. The Registration fee is per student and payable only one time. The Capital Assessment is per family and is payable only one time. Each parent or guardian registering a student, as well as any guarantor institution, is responsible for all payment of school fees.

All payments must be net of expenses. Any balance overdue will be assessed a penalty charge of 1% per month. If a student's fees remain unpaid 30 days after the due date, AOSR reserves the right to deny admittance to classes or to expel the student and the matter will be referred to the school's legal counsel. For payment due dates, please refer to AOSR's Tuition Agreement.

### **Billing preference** (*Check one*)

- 1 invoice for full year (payable in full)     1 invoice per semester     Installment Plan \*

### **Invoice in the name of :** (*Check one*)

- Both parents     Father only     Mother only

### **Address to appear on invoice :**

- Both parents' address     Father's address     Mother's address     Company address (*complete below*)

\_\_\_\_\_  
*COMPANY FULL NAME*

\_\_\_\_\_  
*Street address*

\_\_\_\_\_  
*City & State*

\_\_\_\_\_  
*Zip code*

\_\_\_\_\_  
*E-mail address (PLEASE PRINT LEGIBLY)*

\_\_\_\_\_  
*Country Code*

\_\_\_\_\_  
*Telephone number*

\* The Installment Plan carries a service charge of €300 and divides the first semester tuition amount into two equal payments and the second semester tuition amount into two equal payments. The Installment Plan does not apply to the Registration and Capital Assessment fees.

\_\_\_\_\_  
*Father's last name*

\_\_\_\_\_  
*Father's first name*

\_\_\_\_\_  
*Father's signature*

\_\_\_\_/\_\_\_\_/\_\_\_\_  
*DD MM YY*

\_\_\_\_\_  
*Mother's last name*

\_\_\_\_\_  
*Mother's first name*

\_\_\_\_\_  
*Mother's signature*

\_\_\_\_/\_\_\_\_/\_\_\_\_  
*DD MM YY*

**ANY CHANGES TO YOUR BILLING INFORMATION MUST BE COMMUNICATED TO :**

[Billing@aosr.org](mailto:Billing@aosr.org)

**FOR OFFICE USE :**

**FAMILY CODE** \_\_\_\_\_



## Health Record

**GRADES PRE-K THRU 13**

To be completed by the parent

Student Information (one per student)			
First name:			
Middle name:			
Last name:			
Date of birth:		Gender:	Male <input type="checkbox"/> Female <input type="checkbox"/>
Parent / Guardian name:			
Home address:			
City:		Zip:	
Country:			
Home phone:		Fax:	
Office phone 1:		Office phone 2:	
Email 1:		Email 2:	
Mobile phone 1:		Mobile phone 2:	

The health office must ALWAYS have current contact numbers.

If they are not known now, please submit them as soon as they are known.

Health History			
Does your child:			
• wear glasses or contacts?	Yes	<input type="checkbox"/>	No <input type="checkbox"/>
• have or had frequent ear infections?	Yes	<input type="checkbox"/>	No <input type="checkbox"/>
• have hearing problems?	Yes	<input type="checkbox"/>	No <input type="checkbox"/>
• suffer from allergies?	Yes	<input type="checkbox"/>	No <input type="checkbox"/>
• have a special diet for religious or medical reasons?	Yes	<input type="checkbox"/>	No <input type="checkbox"/>
• take medication on a regular basis?	Yes	<input type="checkbox"/>	No <input type="checkbox"/>
What is the medication?		What dosage?	
List below any serious illnesses and approximate dates.			
Professional counseling/therapy (explain briefly):			
Please explain any medical problems or health concerns of which the school should be aware:			





**Physical Exam**

**GRADES - PRE-K THRU 13**

Mrs. Diane Cullen-Moore is the school's registered nurse. (39) 06.33438321

To be filled out by a physician

<b>Student Information</b>	
First name:	
Middle name:	
Last name:	
Date of birth:	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>
Height:	
Weight:	
Eyes:	
Ears:	
Nose:	
Throat:	
Heart:	
Lungs:	
Abdomen:	
Genitalia:	
Hernia:	
Extremities:	
Posture (spine):	
Skin:	
Allergies:	
Menstrual History:	
General Appraisal:	
Recommendations & Restrictions	

Examining Physician's Stamp

Date: \_\_\_\_\_

\_\_\_\_\_  
Examining Physician's Signature



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## Records Request GRADES PRE-K THRU 13

**This form may be used by the parent or legal guardian to authorize the release of school records.  
If not used, include this form signed with the application for future use.**

<b>Student Information</b>			
First name:			
Middle name:			
Last name:			
Date of birth:		Last grade attended:	

<b>Previous Schools:</b> Most recent at the top			
School Name:			
Address:			
Address:			
Telephone / Email:			
Dates Attended:		Grades Attended:	
School Name:			
Address:			
Address:			
Telephone / Email:			
Dates Attended:		Grades Attended:	
School Name:			
Address:			
Address:			
Telephone / Email:			
Dates Attended:		Grades Attended:	
School Name:			
Address:			
Address:			
Telephone / Email:			
Dates Attended:		Grades Attended:	

**I hereby request and authorize the release of all scholastic records and the results of any standardized or individual testing for my child and ask that this information be sent to:**

**AOSR Admissions  
Via Cassia 811  
00189 - Rome, Italy**

**AOSR Admissions  
PSC 833 BOX 68  
FPO AE 09624-0068**

*Signed* \_\_\_\_\_

*Date* \_\_\_\_\_

*Parent*