REFERRAL FOR TESTING FOR POSSIBLE GIFTED IDENTIFICATION AND/OR SERVICE

Referrals are accepted between April 1 - May 1 and August 1 - September 1; referrals outside of those dates will be held until the next referral window.

I would like to refer the following student for testing to determine possible gifted identification and/or service from the Gifted and Talented Education (GATE) program.

Student’s Name: _________________________ Grade: _____ Current School: ______________________

Referred by: ____________________________ Relationship to Student: _______________________

Parent/Guardian Name: ____________________________

Parent/Guardian Phone: _______________________ Email: ___________________________

Reason for Referral: ___________________________________________________________________

Please indicate with a check mark the area(s) to be assessed:

_________ Superior Cognitive Ability

_________ Specific Academic Ability in Reading

_________ Specific Academic Ability in Math

Please select one of the following two statements below regarding your child’s participation in testing, and sign this form. As soon as the testing is completed and scored, you will be sent written documentation with the results. Please note: If you have given permission to test, assessments will be administered when the evaluator is available in your student’s building.

_________ I give permission for my child to participate in the testing of the above initialed area(s) for possible gifted identification.

_________ I do not give permission for my child to participate in the testing of the above area(s) for possible gifted identification.

Parent/Guardian Signature: ____________________________ Date: _____________

Please return this form to your child’s school principal/office.