REFERRAL FORM
PERMISSION FOR ASSESSMENT OF GIFTED IDENTIFICATION ACADEMICS

PERSON INITIATING REFERRAL: _____DATE _____

Student: _____

Student's Address_____City_____ State_____ Zip_____

Phone: (Home) _____ (Cell)_____ (Work) _____

CIRCLE AREA(S) TO TEST: Cognitive Creativity Reading Math

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To the Parent(s) / Guardian:
Please fill out the form and return to your child's teacher. You may view our *District Policy and Plan for the Identification and Service of Children Who Are Gifted* on the Franklin City School website www.franklincityschools.com under Departments---Curriculum---Gifted Services. Or you may request a copy from the school office.

Grade _____School _____ Classroom Teacher _____

Sex: F M DOB_____ Age _____

Siblings: _____Age_____

_____Age_____

_____ Age_____

Mother's Name_____ Father's Name _____

I understand that by granting my permission, my child will be assessed by designated school personnel and that the information may be shared with teachers, principals, and other appropriate school staff members. I will be informed of whether or not my child qualifies, according to the State of Ohio criteria, for gifted identification.

_____ *PERMISSION TO ASSESS GRANTED* _____ *PERMISSION IS DENIED*

_____ _____ _____
Signature Relationship to Child Date

Dawn M. Harris, Gifted Services Coordinator dmharris@franklincityschools.com (937) 743-8602, ext. 1459