Date Received: _____

SOUTH EUCLID LYNDHURST SCHOOLS

REFERRAL FOR GIFTED IDENTIFICATION

Student Name:	Student ID#:	Date of Birth:

School:	Teacher:	Grade:
Parent/Guardian Name(s):		Phone:
Street Address:	City:	Zip Code:
Referred By:		Referral Date:

(Please Print)

Position of Relationship to Student (Please check all that apply):

☐ Administrator, Guidance Counselor, or Teacher ☐ Parent/Legal Guardian ☐ Self ☐ Peer

THE STUDENT IS REFERRED FOR POSSIBLE IDENTIFICATION AS GIFTED IN THE FOLLOWING AREA(S):

	Reason:
☐ Superior Cognitive Ability	
☐ Specific Academic Ability	
☐ Mathematics	
☐ Science	
☐ Reading/Writing	
☐ Social Studies	
☐ Creative Thinking Ability	
☐ Visual/Performing Arts Ability (Drawing/Painting, Music, Dance, Drama)	

_____ _____/_____/_____

Signature of Person Initiating Referral Date

Note: A parent/guardian may request assessment through verbal or written correspondence to the Building Administrator or to the Gifted Coordinator. The parent/guardian must then complete the **'Referral for Gifted Identification'** form and **the 'Parent Permission for Assessment'** form. If the student or the student's peer is making the referral, a parent signature on the 'Parent Permission for Assessment' form is still required.

PLEASE COMPLETE THE NEXT PAGE

Student Name:	Student ID#:

The assessments administered by the district are approved by the Ohio Department of Education. The South Euclid Lyndhurst City School District typically uses one of the following individual testing instruments:

- InView Cognitive Abilities Assessment
- Terra Nova Achievement Tests
- CogAT

Note: Please see the Assessment Instruments Used for Gifted Identification Pamphlet for the complete list of group and individual testing instruments administered by the district.

Please answer the following questions to help ensure testing accurately reflects your student's ability and/or achievement.

1. Is a second language spoken in the home? ☐ No ☐ Yes
2. If yes, what language(s)? _____
   _____
3. Does your student have an IEP of 504 Plan? ☐ No ☐ Yes
   If yes, please state which plan and the reason: _____
   _____
4. Does your student need accommodations for testing? ☐ No ☐ Yes
   If yes, please specify the accommodation(s): _____
   _____

Please use this space to provide any additional information about your child that you feel may affect testing:

Note: Once parent permission is received, the Gifted Coordinator will contact the student's home school to schedule testing and will notify the parent/guardian of the testing date. The Ohio Department of Education states that testing for gifted identification must occur within 90 days of the test referral date.

PERMISSION

☐ Yes, I give permission for my child to be tested.

☐ No, I do not give permission for my child to be tested at this time.

_____	_____	_____/_____/_____
Please Print Parent/Guardian Name	Signature of Parent/Guardian	Date Signed

Please send the signed and completed forms to:	GREENVIEW CAMPUS, Room 203 **Attn: Beverley Veccia, Gifted Coordinator** 1825 South Green Road South Euclid Ohio 44121