



Office of
Curriculum, Instruction, and Gifted Services
(740) 922-5478 Ext. 12002
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PARENT REFERRAL FORM: GIFTED PROGRAM

CHILD'S NAME: _____

BUILDING: _____

DATE: _____ **GRADE:** _____

PARENT/GUARDIAN MAKING REFERRAL: _____

I feel my child is gifted in the following area(s) as recognized by the state of Ohio:

_____ **Superior Cognitive:** Very well informed and able to master material well and quickly in nearly all subject areas.

_____ **Specific Academic:** Very well informed and able to master material well and quickly in only ONE subject area, which is: _____.

_____ **Creative Ability:** Ideas, which are creative or unusual and approaches problems and topics from a different point of view.

_____ **Visual/Performing Arts:** Ability is approaching the adult level in the following specific area: (check all that apply)

_____ Art _____ Music _____ Drama _____ Dance _____ Other: _____

I feel this student is potentially gifted because: _____

I also want you to know that this child: _____

By making this referral, I understand that my child will be administered gifted assessments by designated school personnel, and that teachers, principals, and/or other appropriate school personnel will have access to needed information. Upon completion of testing, school personnel will inform me of the results of these assessments.

Parent Signature: _____

Office Use Only:

Date rec'd: _____ Gifted Coordinator's Signature: _____