A VITAL LINK
Making a difference together

Licking County Educational Service Center
Office of Gifted Education
145 N. Quentin Road, Newark, OH 43055
P: 740-349-6084/F: 740-349-6107

REFERRAL AND PERMISSION FOR GIFTED EVALUATION

Student Name:_____ Date of Birth: _____
District: _____ Grade:____ Homeroom:_____ Building: _____
Parent/Guardian Name:_____ Phone: _____
Parent/Guardian Email (print VERY clearly): _____
Address: _____
_____

You are one of the best judges of the abilities of your child. Gifted children are a diverse population and each one will exhibit different signs of their intelligence, motivation, and development.

A parent referral does **not guarantee** the student will be placed in gifted services. After receiving this form, the Gifted Coordinator for your district will review previous test scores and will schedule your child for testing during the FALL or the SPRING. The student may be given any assessment from the Ohio Department of Education's list of approved instruments for gifted identification. Testing results will be shared with appropriate school personnel.

Mark the Area/s for Referral:
☐ COGNITIVE ABILITY ☐ MATH ☐ READING ☐ OTHER:_____

1. I request that my child be tested for gifted identification. I understand that my child may be tested in one or more areas by a gifted coordinator, and that prior testing results will also be reviewed.
2. I understand that my child may be given additional assessments based on the results of this evaluation.
3. I understand that my child may be tested on any business-day within 90 days after the referral for gifted evaluation is received by the gifted coordinator.
4. I understand that these testing results will be evaluated for potential placement in gifted services according to my district's placement policies and procedures.
5. I will receive testing results within 30 days of the testing date. I have the right to appeal these results.
6. I understand that neither a parent referral, gifted testing, nor gifted identification ***guarantee*** my child a position in gifted services. Space in gifted services is limited.
7. Please indicate below if your child receives special services and already has a **formal** document outlining testing accommodations: ☐ IEP ☐ 504 ☐ ESL ☐ NONE *Attach documentation if available.

_____ _____ _____
Signature **Relationship to Child** **Date**

If you have questions, please contact your district's Coordinator of Gifted Services at the Licking County Educational Service Center by email or phone.

Heather Clark	**Holly Hartman**	**Alesha Haybin**
Lakewood & Licking Heights	Heath, Johnstown-Monroe, & North Fork	Granville & Licking Valley
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Equal access will be available to all students for screening, further assessment, identification, and placement in eligible services, including minority or disadvantaged students, students with disabilities, and students for whom English is a second language.

To be Completed by Gifted Coordinator Date Received: _____
Previous Area/s of Identification: ◯ SC ◯ MTH ◯ SCI ◯ R ◯ SS ◯ CT ◯ VPA ◯ NONE Coordinator Initials: _____