



ACCELERATION REFERRAL FORM

Student: _____ Student ID: _____ DOB: _____
 School: _____ Grade: _____ Age: _____
 Address: _____ Phone: _____ Email: _____
 Teacher(s): _____ Parent(s)/Guardian(s) _____

Referral Source (Check one):
 Teacher
 Parent/Guardian
 Self/Student
 Other (Please Specify) _____

Referred for possible acceleration in the following area(s):

Whole Grade Acceleration
 or
 Single Subject Acceleration in: (Check all that apply)
 Mathematics
 Science
 Reading
 Social Studies

Does the child or parent need assistive technology or other accommodations in order to attend meetings or understand the content of written and/or verbal information?

Yes (Please explain) No

Please describe how this student exhibits a need for acceleration, which goes beyond the modified curriculum provided in the regular classroom or gifted pull out classroom (if available). Please provide specific examples that support this referral. Please comment on this student's academic skills as well as social and emotional behavior.

Signature of Person Initiating Referral:

Position or Relationship to Student: _____

Phone: _____ **Date:** _____

Signature of Person Receiving Referral:

_____ **Date:** _____

Please return the completed form to the student's teacher, principal, or gifted coordinator.