**N**orthridge **L**ocal **S**chool **D**istrict
Department of Instruction & Student Achievement
*6097 Johnstown-Utica Road*
*Johnstown, OH 43031*
*Phone: (740) 967-6631*
*Fax: (740) 967-5022*

*Mrs. Jaime Scott, Director*

# Parent Referral for Gifted Testing

Date: _____

Student's Name: _____ Date of Birth: _____

School: _____ Grade: _____

Teacher(s) Name: _____

Parent/Guardian Name: _____

Relationship to Child: _____

Parent/Guardian Phone/Email: _____

1. What area(s) do you feel your child is academically talented? Please circle all that apply.

   Cognitively Gifted Reading Math

2. Provide evidence to support your referral: _____
   _____
   _____

3. Has the child been tested previously (at Northridge or another school district)? If so, when and what were the scores: _____
   _____
   _____

Authorization for Assessment

By signing this form, I support a referral for my child to undergo gifted testing.

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Signature Date

*Please return this form to Jaime Scott*
*6097 Johnstown-Utica Road*
*Johnstown, OH 43031*
*Fax: (740) 967-5022*
*jscott@northridgevikings.org*