Parent Referral for Gifted Testing

Please complete this form and return to your child's homeroom teacher.

Student Information

Student Name: _____ Grade: _____ Age: _____

Gender: _____ Birthdate _____ Teacher: _____ Language spoken at home: _____

Does your child have an I.E.P.? *(Please circle one)* **Yes** or **No**

Gifted Testing History

Has your child ever been evaluated for placement in a gifted program? *(Please circle one)* **Yes** or **No** If yes, approximately when did this take place? _____

Parent or Guardian Information

Name of parent or guardian _____

Telephone: _____ Email:_____

Address: _____ City: _____ ZIP _____

Final Parent/Guardian Consent:

Do you give permission for your child to be assessed for giftedness using the Cognitive Abilities Test?

(Please circle one) **Yes** or **NO**

Signature of Parent or Guardian _____ Date _____

Contact the Director of Advanced Learning Experiences with any questions you may have.
602-861-2200 or jmcintosh@wsd7.org