



Northridge Local School District
6097 Johnstown-Utica Road
Johnstown, OH 43031
Phone: (740) 967-6631
Fax: (740) 967-5022

Mrs. Amy Warren, Director of Curriculum

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 Amy Warren
6097 Johnstown-Utica Road
Johnstown, OH 43031
Fax: (740) 967-6631
awarren@northridgevikings.org