



## 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** \_\_\_\_\_