



APPLICATION FOR GIFTED TESTING

Please complete this application and send it to the email below.

Student's Name _____

Student's Birthday _____/_____/_____
Month Day Year

Student's School _____

Parent/Guardian Name _____

Home Address _____

Cell Phone Number _____

Email Address _____

Office use only:

Students' iReady scores:

Reading _____%

Math _____%

Please email this completed document to: Kerry.Ivkovic@clevelandmetroschools.org



**Office of Gifted
Kerry Ivkovic, Director Gifted K-12
Evaluation and Review Permission Form**

Child's Name _____
Date of Birth _____
Address _____
Parent/Guardian _____
Email _____
Cell Phone _____

Chief Executive Officer
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In giving permission, I understand that any or all of the following may occur in accordance with the Ohio Department of Education Model Policy for Academic Acceleration:

- Administration of Assessments (e.g. cognitive, achievement, aptitude, and any other appropriate measures to determine appropriate placement).
- Review of relevant records.
- Observation(s) of my child.
- Interview with caregiver and/or parent/guardian.
- Acceleration Team Evaluation meeting.

No assessment, evaluation review will be done without your written permission.

I understand that if I grant permission, my child will receive assessment(s) by designated school personnel and that their information may be shared, as required, with teacher, principals, and other appropriate school personnel.

Permission is given to conduct the evaluation and review.

Permission is denied.

Parent/Guardian Signature _____