CELINA INDEPENDENT SCHOOL DISTRICT
COMMUNITY • EXCELLENCE • INNOVATION • LEADERSHIP • STEWARDSHIP

Gifted and Talented Appeals Form

Student's Name_____**School:**_____

Grade:_____ **Parent/Guardian Name:**_____

Phone:_____ **Date:**_____

I wish to appeal the Gifted and Talented placement decision of the District GT Selection Committee for the following reason (s):

_____

_____

_____

_____

_____ _____ _____

Parent/Guardian Signature *Relationship to student* *Date*

For District Selection Committee use only

Date of District GT Selection Committee Appeals Meeting:_____

Action of committee:

_____

_____

_____

_____Overturn the original decision and recommend participation in the GT program.
_____Confirm the original decision without further testing.
_____Confirm the original decision after further data collection.

_____ _____

District Committee Signature *District Committee Signature*

Revised January 2026