Phelps Center for Gifted Education
Student Referral Form

Office use only
Date________________________
Time________________________
Tester________________________

Name of student ____ Grade ______ Birth date ________

Address ____ Zip _____________

Parent/Guardian name(s) _______________________________________ Contact # (_____) _____________

Parent/Guardian email address____

School ____________________________________ Teacher____________________________________

New to SPS district? Y / N Previous gifted program? Y / N Grade advanced? Y / N Which grade? ________

Does student currently receive accommodations for any of the following: IEP, 504, or ELL? Y / N ________

When rating students, please think about the student in comparison to other children of similar age, experience, and/or environment

Use the following scale to indicate how frequently you observe the traits and behaviors listed in items 1–11.

6 = always 5 = almost always 4 = often 3 = sometimes 2 = rarely 1 = never

	6	5	4	3	2	1
1. Performs or *shows potential* for performing at remarkably high levels.						
2. Is sensitive to larger or deeper issues of human concern.						
3. Is self-aware.						
4. Shows compassion for others.						
5. Is a leader within his/her group of peers.						
6. Is eager to explore new concepts.						
7. Exhibits intellectual intensity.						
8. Effectively interacts with adults or older students.						
9. Uses alternative processes.						
10. Thinks “outside the box.”						
11. Has intense interests.						

12. Please indicate all content areas where the student shows talent.
____Math ____Reading ____Creative Writing ____Social Studies _____Science ____Arts ____Other

13. Any personal/social development or additional information concerning this student?

Jack Cook Kent Foundation 2007

___________________________________ Signature

______________________ Relationship to student

__________ Date

Please return completed form to: Phelps Center for Gifted Education
934 S. Kimbrough Springfield, MO 65806

Office use only

Test	Tester / Date
W-5	______/______
Add’l	______/______
NNAT	______/______
SAGES	______/______

Date Rec’d ______________

Student # _______________

Springfield Public Schools

Phelps Center for Gifted Education

934 S. Kimbrough
Springfield, MO 65806
417-523-3300 / 417-523-3395 fax

Permission to Evaluate Form

I hereby authorize Springfield Public Schools to conduct all assessments necessary to evaluate my child for gifted services.

I understand it is essential for my child to:

- be physically and mentally prepared to take the evaluation
- know that they may question the examiner if something is unclear
- understand the importance of doing her/his best on the evaluation

I understand that if my child does not qualify for gifted services after the first evaluation, they have the option to repeat it with a minimum of one year between evaluations. In accordance with assessment protocols, after the second evaluation and placement decisions have been determined, the opportunity for additional evaluations is closed.

As the parent/guardian, I am responsible for deciding that my child is both physically and mentally prepared to take the evaluation.

______________________________ ______________________________ ____________
Student Name (Please Print) | Current School Attending | Birth Date

____ ____________________ ____
Home Address/City/Zip Code | Phone Number | Grade

______________________________ ______________________________ ____________
Parent/Guardian Name (Please Print) | Parent/Guardian Signature | Date