



## APPLICATION FOR EARLY ENTRANCE TO KINDERGARTEN

Please complete this application if you feel that your child demonstrates academic achievement, social, emotional, and physical maturity appropriate for kindergarten placement and should be considered for early entrance.

### Student/Family Information

Child's Name: \_\_\_\_\_ Gender: MALE      FEMALE  
FIRST                      MIDDLE                      LAST

Birth Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Language Spoken at Home: \_\_\_\_\_  
MONTH                      DAY                      YEAR

Home Address: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Home/Cell Phone#: \_\_\_\_\_ Work Phone#: \_\_\_\_\_

Email Address: \_\_\_\_\_

### Preschool/Daycare Experience

List the preschools, Head Start, special programs, and other daycare programs attended. Include the teacher names, dates of attendance and phone number.

Name of School/Program	Teacher(s) and Email(s)	Dates of Attendance	Phone Number

Non-School Activities: \_\_\_\_\_

Siblings Living at Home: # of Siblings \_\_\_\_\_ Age(s): \_\_\_\_\_

\_\_\_\_\_                      \_\_\_\_\_                      \_\_\_\_\_  
Print Name of Parent/Legal Guardian                      Parent to sign at date of child testing                      Date

**Please email this completed document to:** [Kerry.Ivkovic@ClevelandMetroSchools.org](mailto: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: \_\_\_\_\_ Phone: \_\_\_\_\_
Parent/Guardian: \_\_\_\_\_
Email: \_\_\_\_\_

In giving permission, I understand that any or all 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.

Print Name of Parent/ Legal Guardian Parent Signature Date

Chief Executive Officer
Dr. Warren G. Morgan II

Board of Education
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Board Chair

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Diana Welch Howell

Ex Officio Members

Michael A. Baston, Ed.D., J.D.

Laura Bloomberg, Ph.D.

Please note: Granting permission does not guarantee access to acceleration options.
Please email this completed document to: Kerry.Ivkovic@ClevelandMetroSchools.org



**EDUCATOR/MEDICAL PROFESSIONAL  
REFERRAL FORM**

*To be completed by a non-family member*

This form is **required** only if the student will be turning 5 years of age on January 1, 2027 or after. It is **recommended** that the parent/guardian bring this form at the time of evaluation if student is turning 5 years of age between August 28, 2026 and December 31, 2026.

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name of person making this referral: \_\_\_\_\_

Title of person making this referral: \_\_\_\_\_

Name of your Organization/Practice: \_\_\_\_\_

Business Address: \_\_\_\_\_ Phone#: \_\_\_\_\_

How do you know the applicant? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Do you feel the applicant would be prepared for Kindergarten in August of 2026. Please explain why or why not:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Briefly state the characteristics you see in the applicant that you feel make him/her school ready:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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