



Canal Winchester Local School District

Parent Referral For Gifted Identification

Student's Name:		Date of Referral:	
Date of Birth:		Grade:	
		Sex:	

Homeroom Teacher:	
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Person Making Referral:			
Parent/Guardian Name(s):			
Relationship to Student:			
Daytime Phone:		E-Mail:	

I am requesting the following testing for my child listed above:

- Language Arts/Reading (Specific Academic)
- Mathematics (Specific Academic)
- Cognitive Ability Test (similar to an IQ test)

Testing is required for identification purposes. Your child will receive testing by designated school personnel and the information may be shared with your child's teachers, principals and other appropriate school personnel. The school district will inform you if your child qualifies for services, according to the State of Ohio criteria, for gifted identification.

- Yes, I give permission for direct testing of intellectual ability and/or individual subject testing for my child listed above to be tested by a school psychologist.

Parent Signature:		Date:	
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Return this form upon completion to:
Jodie Daniels jdaniels@cwls.us Fax (614) 833-2168
Canal Winchester Education Center
100 Washington Street
Canal Winchester, OH 43110