GLOUCESTER COUNTY PUBLIC SCHOOLS
OFFICE OF GIFTED EDUCATION SERVICES
REFERRAL/PERMISSION TO EVALUATE FORM
FOR ACADEMIC SERVICES

Date of Referral_____

Referred By_____

Name of Student_____

Current School _____

Current Grade Level_____

Current Teacher_____

Student ID Number_____

Date of Birth _____

Parents(s)/Guardian(s) Name(s)_____

Mailing Address_____

_____

Home Telephone Number_____ **Work Telephone Number**_____

PERMISSION TO EVALUATE

I understand my child, _____, has been referred for evaluation for Gifted Education Services and that evaluation may involve testing by trained personnel, an evaluation of my child's records and school work, a classroom observation, an interview with my child, and a formal meeting to discuss my child's eligibility for Gifted Education Services. I understand that I will be notified of the results of this formal meeting. By agreeing to an evaluation of my child, I understand that this does not guarantee that my child will receive Gifted Education Services. However, I will be offered the opportunity to review my child's record at anytime and appeal any decision made by the Gifted Education Eligibility Committee.

(Please indicate your decision with an "X" in one of the blank below)

I give permission _____, do not give permission_____, for my child to be evaluated for Gifted Education Services.

Parent/Guardian's Signature_____

Date of Signature_____

Justification Statement for Referral
(To be completed by individual making referral. Please indicate gifted characteristics demonstrated by the student which have led to this referral.)

_____

_____

_____

FOR OFFICE USE ONLY

Principal's Signature and Review Date_____