CIRCEVILLE CITY SCHOOL DISTRICT

Referral for Acceleration

Student Name: _______________________________    DOB: ____/____/_______

Classroom Teacher(s): _______________________________    Grade: __________

Father’s Name: _______________________________    Phone: _____________________

Mother’s Name: _______________________________    Phone: _____________________

Street Address: _______________________________

City: _______________________    Zip: ___________

Parent Email: _______________________________

Referred By (Select One):

☐ Parent   ☐ Teacher   ☐ Principal   ☐ Self   ☐ Other: ________________________

Acceleration Requested:

☐ Single Subject Acceleration (School Year: ________)

☐ Early Entrance to Kindergarten (School Year: ________)

☐ Whole-Grade Acceleration (School Year: ________)

☐ Early Graduation (School Year: ________)

*Required assessments: On-grade level, two grade levels above, and IQ

(Placement must be made before first day of school)

*Required assessments (all subjects): On-grade level, two grade levels above, and IQ

__________________________________________    ____________________________
Person Initiating Referral    Person Receiving Referral

Date: _______________    Date: _______________

For more information concerning acceleration, consult Board Policies po5408, po5464, and po5112.