Circleville City School District

Referral for Gifted Identification

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: _____

The student above is referred for possible identification in:

☐ Superior Cognitive Ability

☐ Specific Academic Ability (select content area(s) below)

Select content area(s):

☐ Math ☐ Science ☐ Reading ☐ Social Studies

☐ Music (select area(s) below)

☐ Vocal ☐ Instrumental

☐ Visual Arts (select area(s) below)

☐ Drawing ☐ Painting ☐ Sculpting

☐ Dance ☐ Drama ☐ Creative Thinking

_____ _____

Person Initiating Referral Person Receiving Referral

Date: _____ Date: _____

*For more information concerning gifted identification, consult Board Policy **po2464**.*