Teays Valley Local School District
385 Viking Way, Ashville, Ohio 43103-9417

Robin Halley, Superintendent
Kyle Wolfe, Assistant Superintendent
Stacy Overly, Treasurer

Phone: (740)983-5000
Fax: (740)983-4158
Website: www.tvsd.us

Gifted Identification Referral Form

Form to be used for recommendation for gifted identification or for re-testing of a child.

For Office use only: Date Received: _____

Check one: ____Parent / Guardian referral _____ Student referral ____ Teacher ____Administrator____Counselor ____ Other: _____

Student information
Person making the referral_____ Relationship to student _____

Date of referral:_____

Student Name: _____Current school: _____
Grade: _____
Date of Birth: _____/_____/_____ Gender: M F
Parent / Guardian name(s):_____
Daytime phone: _____ Evening / other phone: _____
Email: _____
Referral Information
Gifted Identification Areas –check the area you wish to have your child evaluated. Check one:
_____ Superior Cognitive Ability: Students gifted in this area exhibit advanced intellectual ability & reason, or show the potential for reasoning 2-4 grade levels above other students of the same age.
_____ Specific Academic Ability: Students gifted in this area exhibit advanced academic ability and perform, or show the potential for performing at remarkably high level of accomplishment with compared to others of the same age, experience, or environment. National Percentile (NP) = 95% or above.
NOTE: State-based tests (such as OAA, OGT, Achievement, Diagnostic tests are not nationally-normed and therefore are not used for gifted identification.

Previous Identification
Was the student formally identified as gifted by a previous school district? (Check one)
___Yes ___No
If "yes," please complete the following information: Date/Grade of gifted identification: _____
School district: _____ Address: _____
Gifted contact: _____ Phone: _____

Other information

I am requesting gifted identification for the first time: ____Yes ____No (if no, how many times has your child been tested for gifted identification? _____.

Please attach scores of previous testing / dates.

Reason for referral or request for retesting?

For office use only: PAST SCORES
_____Superior Cognitive Ability _____Creative Thinking Ability
_____Specific Academic Ability _____Reading / Writing _____Math
Source: _____ Date: _____

Authorization for Assessment for Gifted Identification
I authorize the Teays Valley Local School District to assess my child for gifted education and that information may be shared
with teachers, principals and other school personnel. I will be informed of whether or not my child qualifies for gifted testing
or has been identified as a result of testing.
_____Check here if student has been identified as needing testing modifications based on ESL, LD, etc…

_____ _____
Signature of parent / guardian (required) Date

PLEASE RETURN THIS FORM TO YOUR CHILD'S BUILDING PRINCIPAL
Timeline: In accordance of Ohio Revised Code, testing will occur within 90 days from the date this completed form is received by the building principal for students new to Teays Valley Local Schools. Current students of the district referred for testing will be scheduled when possible. Results will be shared with the parents / referring person(s) within 30 days.

For Building Administrator
_____I recommend this child to be tested for gifted identification. Date: _____
_____I do not recommend this child to be tested for gifted identification.
Date: _____

For retesting purposes only:
_____I have met with the individuals who have requested retesting and recommend retesting. Date:_____
_____I have met with the individuals who have requested retesting and do not recommend retesting. Date: _____

Principal's comments:

Principal's signature: _____ Date: _____

Return completed forms should be forwarded to Carmen Tarbill at ctarbill@tvsd.us