



## OLMSTED FALLS CITY SCHOOLS GIFTED IDENTIFICATION REFERRAL FORM

Child \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_

If you are referring a student for Gifted Identification (Grades K-12) and Service (Grades 1-8) in the Olmsted Falls City Schools the following scores are required:

**Resource Room Placement (Grades 1-5);** The student must have an IQ score in the superior range, as defined by two standard deviations above the mean minus the standard error of measure. Students must also have a score at the 95<sup>th</sup> percentile or higher in Reading on a state-approved test.

Based on this understanding of Identification and Service I wish to refer the student for testing in the following area(s):  **the selected area(s) for testing.**

**Superior Cognitive Ability (a state-approved IQ test will be administered)** All students in grades 2 and 5 are screened for superior cognitive ability.  
\_\_\_\_\_ IQ Test - Grades K-12

**Specific Academic Ability (a state-approved achievement test will be administered)** All students in grades 2-8 are screened for reading and math.  
\_\_\_\_\_ Reading  
\_\_\_\_\_ Math  
\_\_\_\_\_ Science  
\_\_\_\_\_ Social Studies

\_\_\_\_\_ **Creativity (IQ scores and Gifted Rating Scales will be used to determine Creativity identification).** Students in grades 2 and 5 are screened for creativity.

**Visual and Performing Arts (portfolio or demonstration of work will be evaluated by a trained assessor and appropriate checklists will be administered)**  
\_\_\_\_\_ Dance  
\_\_\_\_\_ Visual Art  
\_\_\_\_\_ Music  
\_\_\_\_\_ Drama

**\* Students referred and identified only in an academic area, creativity, or visual/performing arts will be identified for State of Ohio purposes only and will not be served by the Gifted Intervention Specialist.**

Details about identification and services can be found at the Olmsted Falls website, or a printed copy is available upon request.



# OLMSTED FALLS SCHOOLS

## Permission for Gifted Assessment

Student Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number \_\_\_\_\_

Parent/Guardian \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_ Referred by \_\_\_\_\_

Please check here if student is on a 504 or an IEP

Please check here if English is not the first language of this student.

No assessment will be done without your written permission. Please read the information below and return it to the school by the third Friday of September for fall testing and the third Friday of March for spring testing. Please note that the assessment may not occur until the district MAPS testing is complete. If you have questions, please contact Ms. Anne Miskimins, Gifted Coordinator, at 440-427-6572.

I understand that if I grant permission my child will receive assessment(s) by designated school personnel and that the information may be shared with teachers, principals, and other appropriate school personnel. I will be informed of whether or not my child qualifies according to the State of Ohio criteria for gifted identification. Such identification does not necessarily mean the child will receive gifted services.

Permission is given to conduct the assessment(s)

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Signature

Relationship to child

Date