Licking Regional Educational Service Center

Office of Gifted Education

145 N. Quentin Road, Newark, OH 43055

P: 740-349-6084/F: 740-349-6107

REFERRAL AND PERMISSION FOR ACCELERATION EVALUATION

Student Name: _____ Date of Birth: _____

District: _____ Grade: _____ Homeroom: _____ Building: _____

Parent/Guardian Name: _____ Phone: _____

Parent/Guardian Email (print VERY clearly): _____

Address: _____

<div align="right">(include city & zip code)</div>

Student data will be evaluated for acceleration using a pre-determined process. Placement decisions will be made by an acceleration committee. The student may be given any assessment from the Ohio Department of Education's list of approved instruments for gifted identification. Results will be shared with the parent and appropriate school personnel.

Mark the type of Acceleration Referral:

☐ **SINGLE-SUBJECT ACCELERATION** in the area of … ◯ MATH ◯ SCIENCE ◯ READING ◯ SOC.STUD. ◯ OTHER

<div align="right">Name of Potential Course: _____</div>

☐ **WHOLE-GRADE ACCELERATION** (if approved, the student would skip an entire grade)

1. I request that my child be evaluated for acceleration. I give permission for my child to be tested by a gifted coordinator. I understand that prior testing results may also be reviewed.
2. I understand that my child may be tested on any business-day within 45 days after the referral is received by the gifted coordinator. In addition, the gifted coordinator will provide results within the same 45 days.
3. I understand that these testing results will be evaluated for potential acceleration according to my district's policies and procedures. A parent referral does not *guarantee* my child a position in accelerated placement.
4. I understand that I may appeal the final placement decision, but must do so in writing, submitted to my District's superintendent, within 30 days of the acceleration results letter.
5. Please indicate below if your child receives special services and already has a **formal** document outlining testing accommodations: ☐ IEP ☐ 504 ☐ ESL ☐ NONE *Attach documentation if available.

_____   _____   _____

Signature   **Relationship to Child**   **Date**

Questions or Concerns? Contact your district's Gifted Coordinator at the Licking Regional Educational Service Center

Garnett Andrews	**Heather Clark**	**Holly Hartman**	**Alesha Haybin**
Franklin Local, West Muskingum, Zanesville	Lakewood & Licking Heights	Heath, Johnstown-Monroe, Newark, North Fork	Granville, Licking Valley, Northern Local
740.349.6104	740.349.6105	740.349.6094	740.349.6083
gandrews@laca.org	hclark@laca.org	hhartman@laca.org	ahaybin@laca.org

Equal access will be available to all students for screening, further assessment, identification, and placement in eligible services, including minority or disadvantaged students, students with disabilities, and students for whom English is a second language.

To be Completed by Gifted Coordinator	Date Received: _____
Previous Area/s of Identification: ◯ SC ◯ MTH ◯ SCI ◯ R ◯ SS ◯ CT ◯ VPA ◯ NONE	Coordinator Initials: _____