



**ONTARIO LOCAL SCHOOLS  
GIFTED SERVICES**

**Parent Referral Form for Gifted Testing**

Student's Name: \_\_\_\_\_

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

Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

Grade: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Referred by: \_\_\_\_\_

Please mark the area(s) for possible identification:

**Reason:**

\_\_\_ Superior Cognitive Ability \_\_\_\_\_  
\_\_\_\_\_

\_\_\_ Specific Academic Ability \_\_\_\_\_

\_\_\_ Mathematics \_\_\_\_\_

\_\_\_ Reading \_\_\_\_\_

\_\_\_ Writing \_\_\_\_\_

\_\_\_ Science \_\_\_\_\_

\_\_\_ Social Studies \_\_\_\_\_

\_\_\_ Creative Thinking Ability \_\_\_\_\_  
\_\_\_\_\_

\_\_\_ Visual and Performing Arts \_\_\_\_\_

\_\_\_ Art \_\_\_\_\_

\_\_\_ Music \_\_\_\_\_

\_\_\_ Dance \_\_\_\_\_

\_\_\_ Drama \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship to Student

\_\_\_\_\_  
Date