LELAND SCHOOL DISTRICT INTELLECTUALLY GIFTED REFERRAL FORM

DIRECTIONS: Complete this box only.

Student Name: _____ Date of Birth: _____

Race: **B, W, H or_____** Sex: **M or F** Age: _____ Today's Date:_____

School: LES LMS (circle one) Grade: _____

Name of person making referral (Print):_____

Signature of person making referral: _____

Relationship to student: Teacher_____

Does the student wear glasses? Yes or No Does the student have any allergies? Yes or No

List allergies, if any: _____

List any known medications the student takes: _____

Has the student been referred previously for the intellectually gifted program? Yes or No or Unsure

Does the student have any disabilities or an IEP that should be considered? Yes or No or Unsure

If yes, please describe _____

MEASURES TO SATISFY REFERRAL CRITERIA

1. Measure: _____ Date: _____ Score: _____

2. Measure: _____ Date: _____ Score: _____

3. Measure: _____ Date: _____ Score: _____

LSC REVIEW DETERMINATION

Moves to assessment stage: Yes ___ No _____ Date: _____

Need to collect more data: Date: _____

Identification process terminated: Date: _____

Signatures of LSC Members:

_____ _____

_____ _____

Date Signed: _____