St. Lucie Public Schools

Gifted Referral Form

DEMOGRAPHIC INFORMATION

Student Name:			**ID #:**
DOB:	**Ethnicity:**	**Gender:**	**School:**
Parent/Guardian Name(s):			**Phone #:** **Email:**

PARENT/GUARDIAN CONTACT

Date of Conference: _____

Reason for Referral:

CONSENT TO SCREEN

Parent has signed the "Parent Permission to Access for Individual Instructional Planning" (STS0076) Form, granting permission to screen their child. *Check one*. **____ Yes* ____ No | Date Signed _____**

If signed, please attach to this referral. Academic screenings cannot be completed without STS0076 signed.

ASSESSMENT DATA

Assessment Name & Subject *(most recent)*	Date	Achievement Level	Scale Score	Compared to District

STUDENT SPECIFIC QUESTIONS

How does this student demonstrate a need for advanced curriculum? Please be specific.

Does the student demonstrate a need for advanced curriculum? *Check one*. **____ Yes ____ No**

Does the student work above the regular class curricula? *Check one.* **____ Yes ____No**

If you answered "no" to either question above, please explain why.

ESOL? *Check one.* _____ Yes _____ No
If yes, answer the following:
LEP Level? *Check one.* ___ LY ___ LF ___ LZ
Last ESOL committee meeting? _____

Free/Reduced Lunch? *Check one.* _____ Yes _____ No
If yes, answer the following: Lunch Code: _____
NOTE: The only lunch codes eligible under "Plan B" are 2, 3, 7, 8, 9, H, M, R, T

SCREENINGS

ABILITY			ACADEMIC		
VERBAL Standard Score/%tile	**NONVERBAL** Standard Score/%tile	**COMPOSITE** Standard Score/%tile	**READING** Standard Score/%tile	**MATH** Standard Score/%tile	**WRITING** Standard Score/%tile
/	/	/	/	/	/
Person Responsible/Position:			**Person Responsible/Position:**		
Instrument Used/Date:			**Instrument Used/Date:**		

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SCREENINGS (cont.)

Parent has signed the "Parent/Guardian Consent for Health Screenings and School Related Health Services" (XED0295) Form, granting permission to screen their child for vision and hearing. ____ Yes* ____ No | Date Signed_____

If signed, please attach to this referral. H/V screening cannot be completed without XED0295 signed.

HEARING				VISION			
Date:				**Date:**			
	1000Hz	**2000Hz**	**4000Hz**		**FAR**	**NEAR**	**Circle One**
R				**R**	20/	20/	P F
L				**L**	20/	20/	P F

Audiometric Screening at 25db	Muscle Balance	Plus Lens (+ 1.75)	Color Perception
Passed: _____ Failed: _____	P F	P F	P F

Person Responsible/Position: _____ **Instrument Used: _____** **Further Evaluation Required? Yes ___ No___** (*If yes, attach report)*	**Person Responsible/Position: _____** **Instrument Used: _____** **Further Evaluation Required? Yes ___ No___** (*If yes, attach report)*
Comments	**Comments**

NEXT STEPS

Please check one: ____ Further evaluation is not requested at this time

____ Further evaluation is requested at this time*

***If this is checked, be sure to 1) obtain consent from the parent/guardian for a formal gifted evaluation through PEER, 2) review/provide Procedural Safeguards to the parent/guardian, 3) Complete section 1 of I01 Form and provide form to Data Specialist for input.

NOTES *(optional)*

TEAM MEMBERS

School Counselor _____ **Parent/Guardian _____**

School Psychologist _____ **Parent/Guardian _____**

Teacher _____ **Other _____**

Teacher _____ **Other _____**