

# Permission for Assessment

To the Parents/Guardians of: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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

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

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Referred by: \_\_\_\_\_ for \_\_\_\_\_.

**No assessment can be done without your written permission.** The following assessments **may** be administered to your child:

- |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
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| <input type="checkbox"/> Cognitive Abilities Test – Form 7<br><input type="checkbox"/> Wechsler Abbreviated Scale of Intelligence (WASI)<br><input type="checkbox"/> ACT Assessment Program<br><input type="checkbox"/> InView<br><input type="checkbox"/> Iowa Test of Basic Skills<br><input type="checkbox"/> Wechsler Individual Achievement Test (WIAT-III)<br><input type="checkbox"/> Scales for Rating the Behavior Characteristics of Superior Students (SRBCSS)<br><input type="checkbox"/> PLAN<br><input type="checkbox"/> Stanford-Binet Intelligences Scales<br><input type="checkbox"/> (GATES) Gifted and Talented Evaluation Scales | <input type="checkbox"/> Cognitive Abilities Nonverbal Test<br><input type="checkbox"/> Wechsler Intelligence Scale for Children (WISC-IV)<br><input type="checkbox"/> SAT I Reasoning Test<br><input type="checkbox"/> TerraNova<br><input type="checkbox"/> Woodcock-Johnson (WJ-III) Tests of Achievement<br><input type="checkbox"/> EXPLORE<br><input type="checkbox"/> DAS (Differential Abilities Scale - II)<br><input type="checkbox"/> Clark’s Drawing Abilities Test<br><input type="checkbox"/> Ohio Department of Education Adjudicator’s Rating Sheets<br><input type="checkbox"/> Audition, Display, or Performance |
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Other: \_\_\_\_\_

Please read the information below and return it to school by \_\_\_\_ / \_\_\_\_ / \_\_\_\_ . If you have questions, please contact \_\_\_\_\_, \_\_\_\_\_ (name) \_\_\_\_\_ (position) at \_\_\_\_\_ (phone).

I understand that if I grant permission, designated school personnel will assess my child 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 for gifted identification, according to the criteria defined by the State of Ohio.

- I grant permission to conduct the assessment(s).
- I deny permission (process of gifted identification ends).

\_\_\_\_\_  
 (signature) (relationship to child) \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (date)

PLEASE RETURN TO ONE OF THE FOLLOWING:  
PRINCIPAL, CLASSROOM TEACHER, OR BUILDING’S GIS