

Date: _____ **PERMISSION TO TEST FOR GIFTED SERVICES**

To the Parents/Guardians of _____,

Your child has been referred for further assessment for gifted identification purposes. At Roosevelt Elementary School District, we administer the CogAT to help us determine whether your child should be receiving specialized services for the gifted and talented. This identification procedure is in compliance with state and federal guidelines.

Parents will be notified of the test results by letter within 30 school days of the test date. You may request further explanation of the test results from the campus gifted coordinator. Your permission is required to test your child for gifted identification. Please indicate your preference below and return it to the classroom teacher as soon as possible.

Sincerely,

Gifted Coordinator
Roosevelt School District

Student's School: _____ Student's Name: _____

Student ID #: _____ Birthdate: _____ Grade: _____

Homeroom Teacher Name: _____

 I give permission for my student to be tested for the Gifted Program. I do not give permission for my student to be tested for the Gifted Program._____
(Signature of Parent/Guardian)_____
(Date)