Siuslaw School District 97J
Special Programs Department
www.siuslaw.k12.or.us

Parent Referral for Talented and Gifted Evaluation

Student Name: _____ Date of Birth: _____ Grade: _____

Teacher: _____ School: _____

Date of Referral _____ Name of parent/guardian: _____

Phone: _____ Email: _____

Please complete the following questions:

1. Do you feel this student is academically talented in **reading?** Yes No Uncertain
2. Do you feel this student is academically talented in **math?** Yes No Uncertain
3. Do you feel this student is **intellectually gifted*?** Yes No Uncertain
   (*gifted across all domains)

What is your child's area(s) of academic strength or area(s) of intense interest?

Are there subject areas that your child learns more quickly than others? Explain.

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What are some areas/subjects your child may find difficult?

What goals do you have for your child this school year?

Is there other information you would like the school to know, or any suggestions to help your child learn to their fullest potential?

Signature of person filling out form: _____ Date: _____

This completed referral needs to be returned to the TAG coordinator to begin the evaluation process. If you have any questions please contact:

Kelly Dotson
Siuslaw School District TAG Coordinator
(541) 997-8241 x6414
kdotson@siuslaw.k12.or.us