



HUDSON CITY SCHOOLS

GIFTED REFERRAL / PERMISSION FOR ASSESSMENT

Please send completed forms to:
Derek Hatcher, Gifted Services Coordinator
83 North Oviatt St., Hudson, OH 44236
Fax: 330-653-1329
HatcherD@hudson.k12.oh.us

Referred by:

- Teacher
- Parent/Legal Guardian
- Student (self-referral)
- Other (specify) _____

Student _____ Teacher _____ Grade _____

Parent(s)/Guardian(s) _____ Phone _____

Address _____ Email _____

Student is referred for possible gifted identification in the following area(s):

- Superior Cognitive Ability

By signing this form, I authorize the Hudson City School District to conduct appropriate assessments to determine gifted identification eligibility for my child. I understand that I will receive the results of the assessment within 30 days of the scoring of the assessment.

Parent/Guardian Signature

Date

Please return this form to Mr. Hatcher at Hudson Middle School.

No assessments will be administered without parent permission.