_____
TEST DATE

ROCKFORD PUBLIC SCHOOLS
DEPARTMENT OF GIFTED EDUCATION
201 South Madison Street
ROCKFORD, IL 61104 (815) 966-3182

CONSENT FOR TESTING

PLEASE COMPLETE ALL AREAS OF THIS FORM AND BRING IT WITH YOU THE DAY OF TESTING.
NO STUDENT WILL BE ADMITTED TO THE TEST SESSION WITHOUT A COMPLETED CONSENT FORM.

LEGAL NAME OF CHILD: _____ ___M ____F
Last Name First Name

DATE OF BIRTH: MO._____ DAY _____ YR _____ CURRENT SCHOOL_____

CURRENT GRADE: CIRCLE ONE: KDG. 1 2 3 4 5 6 7 8 9 10

ETHNIC STATUS: CIRCLE ONE

1-AFRICAN AMERICAN 2-CAUCASIAN 3-NATIVE AMERICAN
4-ASIAN/PACIFIC ISLAND 5-HISPANIC 6-MULTI/RACIAL

I give consent for my child to be tested for the ROCKFORD PUBLIC SCHOOLS' Centralized Gifted Program. I understand that the scores from this testing may be shared with public school personnel and that gifted program staff might obtain data regarding my child's achievement levels and approach to academic tasks from his/her school.

_____ DATE: _____
PARENT/GUARDIAN SIGNATURE

_____ _____ _____, IL _____
ADDRESS BOX#/APT# CITY ZIP

Mother: _____ _____ _____
HOME PHONE BUSINESS PHONE EXTENSION

Father: _____ _____ _____
HOME PHONE BUSINESS PHONE EXTENSION

CONSENT FRM YS/sp pink-single