Revised 12/2021

Fairview Park City Schools
Academic Acceleration Referral and Permission to Evaluate

Child's Name: **Date of Birth:**

Grade: **School:**

Parent(s)/Guardian(s) Name(s):

Address: **Telephone:**

Email:

Type of Acceleration:

_____ Whole Grade: From Grade ___ To Grade ___

_____ Individual Subject Area: Subject Area(s):_____

_____ Early Graduation from High School

Reasons for Academic Acceleration Referral (Please be very specific. Attach any additional information and available documentation to this form.):

_____

_____

_____

_____

_____ _____
Signature of person(s) initiating referral Position or Relationship to student

_____ _____ _____
Name (please print) Phone Date

_____ _____
Signature of person receiving referral Date

I understand by signing below, that I am granting permission for the Fairview Park City Schools Acceleration Evaluation Committee to assess _____ for possible
(please print student name)
academic acceleration. All assessments will be done during the school day. I will be informed of the evaluation for academic acceleration results.

_____ Permission is given to conduct the evaluation for acceleration.

_____ Permission is denied.

_____ _____
Parent/Guardian Signature Date

RETURN TO BUILDING PRINCIPAL

Copies: Parent, Student Permanent File