CLEVELAND METROPOLITAN SCHOOL DISTRICT

APPLICATION FOR EARLY ENTRANCE TO KIINDERGARTEN

Please complete this application if you feel that your child demonstrates academic achievement, social, emotional, and physical maturity appropriate for kindergarten placement and should be considered for early entrance.

Student/Family Information

Child's Name: _____ Gender: MALE ☐ FEMALE ☐
FIRST MIDDLE LAST

Birth Date: _____/_____/_____ Language Spoken at Home: _____
MONTH DAY YEAR

Home Address: _____

Parent/Guardian Name: _____

Relationship to Child: _____

Home/Cell Phone#: _____ Work Phone#: _____

Email Address: _____

Preschool/Daycare Experience

List the preschools, Head Start, special programs, and other daycare programs attended. Include the teacher names, dates of attendance and phone number.

Name of School/Program	Teacher(s) and Email(s)	Dates of Attendance	Phone Number

Non-School Activities: _____

Siblings Living at Home: # of Siblings _____ Age(s): _____

_____ _____ _____
Print Name of Parent/Legal Guardian | Parent to sign at date of child testing | Date

Please email this completed document to: Kerry.Ivkovic@ClevelandMetroSchools.org

CLEVELAND METROPOLITAN SCHOOL DISTRICT

EDUCATOR/MEDICAL PROFESSIONAL REFERRAL FORM

To be completed by a non-family member

This form is ***required*** only if the student will be turning 5 years of age on January 1, 2026 or after. It is ***recommended*** that the parent/guardian bring this form at the time of evaluation if student is turning 5 years of age between October 1, 2025 and December 31, 2025.

Child's Name: _____ Date of Birth: _____

Name of person making this referral: _____

Title of person making this referral: _____

Name of your Organization/Practice: _____

Business Address: _____ Phone#: _____

How do you know the applicant? _____

_____

_____

Do you feel the applicant would be prepared for Kindergarten in August of 2025. Please explain why or why not:

_____

_____

_____

Briefly state the characteristics you see in the applicant that you feel make him/her school ready:

_____

_____

_____

Please email this completed document to: Kerry.Ivkovic@ClevelandMetroSchools.org

CLEVELAND METROPOLITAN SCHOOL DISTRICT

Office of Gifted
Kerry Ivkovic, Director, Gifted K-12
Evaluation and Review Permission Form

Child's Name: _____ Date of Birth: _____

Address: _____ Phone: _____

Parent/Guardian: _____

Email: _____

In giving permission, I understand that any or all the following may occur in accordance with the Ohio Department of Education Model Policy for Academic Acceleration:

- Administration of Assessments (e.g. cognitive, achievement, aptitude, and any other appropriate measures to determine appropriate placement).
- Review of relevant records.
- Observation(s) of my child.
- Interview with caregiver and/or parent/guardian.
- Acceleration Team Evaluation meeting.

No assessment, evaluation review will be done without your written permission.

I understand that if I grant permission, my child will receive assessment(s) by designated school personnel and that their information may be shared, as required, with teacher, principals, and other appropriate school personnel.

☐ Permission is given to conduct the evaluation and review.

☐ Permission is denied.

_____ _____ _____

Print Name of Parent/ Legal Guardian | Parent Signature | Date

Please note: Granting permission does not guarantee access to acceleration options.
Please email this completed document to: Kerry.Ivkovic@ClevelandMetroSchools.org

1111 E. Superior Ave. #1752
Office: 216.838.0131 I Cell: 216.212.6704
Kerry.Ivkovic@ClevelandMetroSchools.org