Note: this is NOT A THERAPEUTIC MENTORING REFERRAL FORM. Please visit http://childrensfriend.net/services/ for that form

Children's Friend and Family Services VOLUNTEER Youth Mentoring Program Mentee Referral Form

Please return this form via mail, email, or fax To Attn: Samantha Alves, Director of Youth Mentoring
Children's Friends and Family Services 110 Boston St, Salem MA 01930 Fax 978 740 9145 Email: salves@childrensfriend.net

MENTEE APPLICANT Information:

Name_____**Nickname**_____
First Last
Home Address:_____ **Mentee Email**_____
Street City State Zip

Gender Identity (Check one):: Male ___Female _____Other _____
Language Spoken In the Home _____**Secondary Language** _____
Date of Birth _____ **School**:_____ **Grade**: _____
Who does mentee live with? Please prove names, ages, and relationship.
_____
_____

Does youth have a therapist? (Check one): No___ Yes___ Name:_____ Agency: _____
Primary Care Physician:_____
PCP Address and Phone:_____
Health Insurance:_____ **Insurance #**:_____
Is mentee on any medication? If so, please list:_____
Does mentee have any allergies? If so, please list:_____
Does mentee have any fears/Phobias (dogs, heights, water, etc)?_____
Does child have a history of homelessness? If yes, how recently?_____
Does mentee have a history of abuse/trauma? If so, please explain_____
_____
_____

Parent/Guardian Information:
Parent(s)/Guardian(s) Name:_____
Language Spoken In the Home _____ **Secondary Language** _____
Maintains (please circle one) full / legal / physical **custody of child.** **Relationship To Child** _____

Address:_____
Street City State

Home phone:_____ **Cell phone**:_____ **Email**:_____

Referral Source Information: **Date of Referral** _____

Name _____**Relationship To Child** _____ **Phone** _____**Email** _____

If referral source is not parent/guardian, name of affiliate organization _____

Reason for Referral:_____
_____
_____
Parent/ Guardian has given consent for referral (Check one): In Person _____ Over the Phone:____ Email: _____