



## Mentee Referral Form

Referral Agency: \_\_\_\_\_

Agency Contact Person: \_\_\_\_\_ Phone # \_\_\_\_\_

Parent/ Guardian \_\_\_\_\_

Social Worker Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Social Worker Supervisor Name: \_\_\_\_\_ Phone # \_\_\_\_\_

If DCF, Office: \_\_\_\_\_

### **EMERGENCY CONTACT PERSON**

Name \_\_\_\_\_ Phone # \_\_\_\_\_

### **PERSONAL DATA**

Name: \_\_\_\_\_ Age \_\_\_\_ Date of Birth \_\_\_\_\_

Phone # \_\_\_\_\_ Social Security # \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Racial and/or Ethnic Background \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_

### **HEALTH DATA**

Insurance Provider \_\_\_\_\_ Provider # \_\_\_\_\_

Health Care Provider \_\_\_\_\_ Phone # \_\_\_\_\_

Are there any health concerns yes  no , if yes please explain.

\_\_\_\_\_

Does person have any medical conditions (i.e. allergies, asthma) that might restrict activities? yes  no , if yes please explain.

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\_\_\_\_\_

Are there any dietary concerns yes  no , if yes please explain.

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Is this person currently taking any medication? yes  no , if yes please list medications.

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Are there any mental health concerns? yes  no , if yes please explain.

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**Household Members**

Name	Relationship	Age	Gender m/f	Home y/n

Why do you feel your child needs a mentor?

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What do you hope your child will gain from a relationship with a mentor?

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Does the mentee have a parent who is incarcerated? \_\_\_\_\_

I give permission for \_\_\_\_\_ to participate in CCC's Mentoring Program.

Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_