

Mentor Program Interest Form  
(To Be Completed by the Parent/Guardian)



**Personal Information**

Youth's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender: Male \_\_\_\_ Female \_\_\_\_ Other \_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Parent Cell Phone #: \_\_\_\_\_

Race: \_\_\_\_ African American \_\_\_\_ Caucasian \_\_\_\_ American Indian  
\_\_\_\_ Hispanic/Latino \_\_\_\_ Asian American \_\_\_\_ Other

School: \_\_\_\_\_

Grade: \_\_\_\_\_ Social Worker/Counselor: \_\_\_\_\_

**Parent(s)/Guardian(s):**

**Guardianship**

Name: \_\_\_\_\_ D.O.B.: \_\_\_\_/\_\_\_\_/\_\_\_\_ Race: \_\_\_\_\_ Yes / No

Name: \_\_\_\_\_ D.O.B.: \_\_\_\_/\_\_\_\_/\_\_\_\_ Race: \_\_\_\_\_ Yes / No

Parent/Guardian Email: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Please answer all the following questions as completely as possible.**

Is your child available to meet with a mentor up to eight hours per month and have contact at least once a week for a minimum of one year? Please explain any scheduling issues.

Is your child currently having any problems either at home or school?

Does your son/daughter have any physical limitations that should be considered during our matching process?

*Please note: Mentors are not allowed to distribute medications. Sending medications on visits is not allowed unless your child can take them on their own and without supervision. Will this be an issue for participation in the program?*

Are you concerned about your child's emotional health and well-being?

