Youth Mentoring Services
of Niagara County
86 Park Avenue, Lockport, NY 14094 • ymsnc@roadrunner.com
(716) 434-1855 • Fax (716) 434-2242 • www.ymsnc.org

# APPLICATION FOR YOUTH MENTORING SERVICES

Date: _____ Completed By: _____

Relationship to Child: _____ Referred By: _____

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Child's Full Name: _____

Date of Birth: _____ Age: _____ Race (for statistical purposes only): _____

Address: _____ City: _____ Zip Code: _____

Phone: _____ Email Address: _____

School: _____ Grade: _____

Special Needs: _____

Interests: _____

Medical Conditions that may impact participation (Allergies, AD/HD, etc.): _____

Current Medications: _____

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Please check all that apply:

☐ Lives in single parent home – Who has residential custody? : _____

☐ Lives in blended home – parent has remarried

☐ Lives in blended home – children in home have different parent(s)

☐ Lives with grandparent head of household

☐ Parent(s) are deceased – Mother Father Both

☐ Parent(s) are incarcerated – Mother Father Both

☐ Substance issues in the family – who? : _____

☐ Eligible for SNAP (food stamps)

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Please check any areas that apply to your concerns for your child:

☐ Hygiene ☐ Academics

☐ Self-Awareness -- Can child identify his/her emotions, thoughts, and behavior?

☐ Self-Management -- Does child manage his/her behavior in different situations?

☐ Social Awareness -- Does child understand and respect differences between people?

☐ Relationship Skills -- Can child maintain healthy relationships with peers and adults?

☐ Responsible Decision Making -- Does child make appropriate choices?



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## PERMISSION FOR YOUTH MENTORING SERVICES

Emergency Contact other than Self:
Name: _____ Phone: _____

I agree to have my child _____, participate in the Youth Mentoring Services program.

Any pictures taken may be used for publicity ☐ Yes ☐ No

Parent Signature: _____ Date: _____