



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: _____

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: _____

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)

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: _____
