

(B) SCHOOL INFORMATION

SCHOOL ATTENDING: _____ TELEPHONE: (_____) _____

ADDRESS: _____ Postal Code: _____

GRADE: ____ TEACHER: _____ PRINCIPAL: _____

WHAT IS THE REASON FOR REFERRING THIS CHILD TO YOUTH ASSISTING YOUTH?

- behavioral emotional parenting cultural other

PLEASE NOTE THAT BOYS 6-9 YEARS OLD, ARE OFTEN MATCHED WITH FEMALE VOLUNTEERS. IF YOU OR THE CHILD'S PARENTS HAVE ANY QUESTIONS, PLEASE CONTACT AN INTAKE COORDINATOR.

DOES THIS CHILD HAVE ANY SPECIAL NEEDS? Yes No If yes, please describe:

DOES THIS CHILD HAVE ANY MEDICAL ISSUES? (including allergies)

PLEASE GIVE A BRIEF DESCRIPTION OF THE CHILD: (include likes, dislikes, interests, groups to which he/she belongs, etc.)

PLEASE GIVE A BRIEF DESCRIPTION OF THE FAMILY (i.e. cohesiveness, supervision, difficulties, etc.)

WHAT LEVEL OF COOPERATION DO YOU ANTICIPATE BETWEEN THE CHILD'S PARENTS AND THE VOLUNTEER? Low Medium High If Low or Medium, please explain:

ARE THERE ANY OTHER AGENCIES INVOLVED WITH THE FAMILY? (past and present)

AGENCY NAME	TELEPHONE	Contact Person	Duration (when?)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

A Youth Volunteer/Child match is based upon common interests, compatibility and close proximity to each other. Youth Assisting Youth strives to promote multiculturalism. We ask for your cooperation in adhering to our multicultural policy. Thank you.

Youth Assisting Youth's mentoring process relies on the attributes and characteristics of both Junior and Youth Volunteer.

SIGNATURE OF PARENT/GUARDIAN

DATE:

SIGNATURE OF REFERRING WORKER

DATE:

Please mail to one of the following addresses or call for more information:

Head Office: 5734 Yonge Street, Suite 401, Toronto, Ontario M2M 4E7

Telephone: (416) 932-1919, **Fax:** (416) 932-1924

FOR YAY OFFICE USE:

Date Received at YAY:

FoxPro Number Assigned: _____

New Referral: _____

Assigned to Case Coordinator: _____

Reassessment: _____

HOST: Yes No



YOUTH ASSISTING YOUTH
THE YOUTH MENTORING PEOPLE™

Head Office 5734 Yonge Street Suite 401 Toronto Ontario M2M 4E7 Telephone 416 932 1919

Website www.yay.org Email mail@yay.org Fax 416 932 1924 Toll Free 1 877 932 1919

CONSENT TO RELEASE INFORMATION (Agency)

NAME OF CLIENT: _____

DATE OF BIRTH: _____

I/We hereby authorize:

REFERRING WORKER'S NAME: _____

NAME/AGENCY: _____

ADDRESS: _____

CONTACT INFORMATION: _____

to release to:

**Youth Assisting Youth
5734 Yonge Street
Suite 401
Toronto, Ontario
M2M 4E7**

Have you made the parent/guardian aware of Youth Assisting Youth and of this referral? Yes No

Any and all information about the above named client

pertaining to: interests, personality traits, behavioral concerns and special needs

for the purpose of: finding a volunteer.

Signature of Parent/Guardian

Relationship to Client

Date

Signature of Client

Date

Signature of Witness (Referring Worker)

Date