Youth Assisting Youth
5734 Yonge St., Suite 401 | Toronto, ON | M2M 4E7
Telephone: 416.932.1919 | Fax: 416.932.1924 | Toll Free: 1.877.932.1919 |
Email: mail@yay.org

**Child/Youth Referral Package (6-15 years old)**

Non-Newcomers only – Please contact the office for the Newcomer Referral Form

*Please read carefully and print clearly. Incomplete forms will not be accepted, no exceptions.*

The match with a Volunteer is based upon common interests, compatibility and close proximity to one another.

Youth Assisting Youth strives to promote diversity. We ask for your cooperation in adhering to our Access and Equity Policy.

**Parent/Guardian(s):** Please note that the **referral can only be completed** by a worker from an organization, health practitioner, School Board, or any other agency that is currently involved.

**Referring workers:** Please complete the form to the best of your knowledge and ensure the signature fields have been signed. Incomplete applications will not be accepted.

**It is the responsibility of the worker and the child's parent/guardian(s) to confirm that we have received the application.**

If discharging the client after the referral, please provide the closure date and the name of the new worker.

Chose one of the following to submit your application:

| | |
|---|---|
| **By mail** | **Youth Assisting Youth**<br>**5734 Yonge St., Suite 400. Toronto, ON. M2M 4E7** |
| **Email** | **intake@yay.org (scan and email)** |
| **Fax** | **416-932-1924** |

**Referral Application – PLEASE NOTE THAT ALL INFORMATION IS CONFIDENTIAL** **Date:** MM / DD/ YYYY

***To be completed by the referring worker in conjunction with parent/guardian(s)***

Where did you learn about Youth Assisting Youth 1-to-1 Mentoring Program?:

- ☐ Google Search
- ☐ Colleague or Employer
- ☐ I was informed about the program by Youth Assisting Youth's Outreach Coordinator
- ☐ I was informed about the program by another employee of Youth Assisting Youth
- ☐ I do not remember – I have known about Youth Assisting Youth for a long time
- ☐ Other: _____

Reason for referral:

| **Social** | **Behavior** | **Emotional** | **Trauma** |
|---|---|---|---|
| ☐ Learning Disability | ☐ Aggressive | ☐ Depression | ☐ Emotional Abuse |
| ☐ Disability | ☐ Withdrawal | ☐ PTSD | ☐ Sexual Abuse |
| ☐ Educational | ☐ Defiant | ☐ Self-Harm | ☐ Physical Abuse |
| ☐ Anxiety | ☐ Passive | ☐ Anger | ☐ War torn country |
| ☐ Cultural | | | ☐ Witnessed abuse |
| ☐ Bullied | | | ☐ Grief |
| ☐ Bully | | | ☐ Divorce/Separation |

☐ **Other:** _____

**Please print clearly:**

Child/ Youth Name _____

*First name* *Last name*

Date of Birth _____ (mm/dd/yyyy) _____ (child must be 6-15 years old)

Gender ☐ Male ☐ Female ☐ Other _____

Address _____ Apt. # _____

City: _____ Buzzer Code: _____ Postal Code: _____

Home Phone _____ Cell Phone _____

Parent/Guardian E-mail: _____

*(Please provide your frequently used email address to receive program and event updates, this information will not be shared)*

Once enrolled in our Peer Mentoring Program, participants are eligible to register for the following programs. Please select the program(s) that your child may be interested in:

- ☐ 1:1 Virtual Tutoring Program (Weekly sessions to help with homework during the school year
- ☐ Girls Empowerment Program (8-week program to build social skills, confidence and self-awareness)
- ☐ Boys Empowerment Program (8-week program to build social skills, confidence and self-awareness)
- ☐ 1:1 Counseling (individual counseling sessions to help with anxiety, depression & other mental health issues)
- ☐ Mental Health Self-Care Training (Group workshops to help reduce stress and improve mental health

**Emergency Contact** *(other than parent)*:

Phone Relationship to Child

**Parent/Guardian(s)**

Parent/Guardian Name

Date of Birth ase note relationship to child

Can we contact the parent/guardian(s) at work? ☐ Yes ☐ No

Where? Work Phone

**Custody Order Information**

What is the legal/court order regarding the above child?

☐ Sole Custody ☐ Sole Custody with visits ☐ Joint Custody ☐ Supervised visits ☐ Other

If other, please explain:

Are there any other legal/court provisions that we should be aware of? (e.g.: restraining order)

☐ Yes ☐ No

If yes, please explain:

***Please note: Failure to complete the Custody Order Information (if applicable) can result in the cancellation of this referral.***

**Other Parent** (Only answer this section if you have joint custody of the child)

Name

Address (if different from above)

Home Phone Cell Phone

If not living in the same household, does the child visit the other parent? How often?

Is the other parent aware of this application to the program? Yes No

**Family Relationship**

Please write the name of any other people living in the same household as the child.

| Name | Age | Gender | Relationship |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Please give a brief description of the family: (i.e. cohesiveness, supervision, difficulties, etc.)

**Medical History**

Does the child have any medical concerns, conditions or allergies? Yes No

If yes, write down the name and the dose of medication(s):

Is the child on any medication? Yes No

If yes, please explain:

If YES for the question above, does the child know how to administer their medication on their own?

☐ Yes ☐ No

Please check the following that best describes the child:

| | | | |
|---|---|---|---|
| ☐ Busy | ☐ Lonely | ☐ Outgoing | ☐ Withdrawn |
| ☐ Friendly | ☐ Carefree | ☐ Shy | ☐ Overactive |
| | | | ☐ Aggressive |

**School Information**

School

Address City Postal Code

Phone Grade Teacher

**Social Activities**

Is the child interested or active in: (check as many as applies)

☐ sports ☐ religious/spiritual activities ☐ group activities ☐ other organized activities?

If yes, please list:

Is the child aware of the application to Youth Assisting Youth?

☐ Yes ☐ No

If yes, what was the reaction?

**Referring Source**

Name: Title:

Agency/ Organization:

Telephone: Ext.: Email:

How long have you worked with this child?

Will there be any follow-up after the referral regarding this child/youth? ☐ Yes ☐ No

Referral Date:

Reason for referral:

What level of cooperation do you anticipate between the child's parent(s)/guardian(s) and the volunteer?

☐ Low ☐ Medium ☐ High

If low or medium please explain:

Is the mentee aware of the application to Youth Assisting Youth?

☐ Yes ☐ No

If yes, what was their reaction:

Is the child involved with any other community or similar mentoring agency or program? ☐ Yes ☐ No

1. Agency Name: Phone:

Contact Person:

2. Agency Name: Phone:

Contact Person:

YOUTH ASSISTING YOUTH
MENTOR • GROW • SUCCEED

**CONSENT TO RELEASE INFORMATION BETWEEN AGENCIES**

**Child/Youth Name** _____

**D. O. B.** _____ **(mm/dd/yyyy)**

**I hereby authorize:**

**Referring Worker's Name** _____

**Agency/ Organization** _____

**Telephone** _____ **Ext.** _____ **Title** _____

**Email** _____

**To release to:**

**Youth Assisting Youth**
**5734 Yonge Street, Suite 400. Toronto, ON. M2M 4E7**

**Any and all information regarding the above named client pertaining to: personality traits, behavioral concerns and special needs for the purpose of: finding a volunteer mentor.**

**Have you informed the parent/guardian(s) of the Youth Assisting Youth program and of this referral?**

☐ Yes ☐ No

**I HEREBY ACKNOWLEDGE THAT THE ABOVE INFORMATION IS ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE.**

_____ _____

**Signature of Parent/Guardian** **Date**

_____ _____

**Signature of Referring Worker (witness)** **Date**