



Mentee Application

Contact Information

Youth's Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Caregiver's Phone #: _____ May we text you? ___Yes___ No

Youth's Cell Phone # _____ May we text you? ___Yes___ No

Youth's Email: _____

Sex: M F Age: _____ Race/Ethnicity: _____

Date of Birth: _____

Primary Language: _____ Other Languages Spoken: _____

Academic:

Name of School: _____ Grade: _____

Career Goal: _____

Interests:

Favorite types of music: _____

Favorite Singer: _____

Favorite TV shows: _____

I like to read books : Yes_____ No_____ About:_____

My favorite sports teams are: _____

I like these pets: _____

I would like extra help with my school work: _____ Yes _____ No

Please circle all the activities you are interested in:

Playing Sports:	Watching Sports:	Outdoor Activities:	Indoor Activities:	Other Activities:
Basketball	Basketball	Fishing	Cooking	Arts and Crafts
Football	Football	Hiking	Library	Tennis
Baseball / Softball	Baseball / Softball	Park	Board Games	Dancing
Hockey	Hockey	Bike Riding	Movies	Gardening
Soccer	Soccer	Walking	Shopping	Animals
Ice Skating	Ice Skating	Beach	Yoga	Drawing
Volleyball	Volleyball	Kayak / Canoe	Singing	Writing
Gym / Exercise	Gymnastics	Roller-skating	Listening to Music	Sewing
Swimming	Track/Field	Skateboarding	Video Games	Reading

Please list any other hobbies or areas of strong interest:

Please circle the response that is closest to how you really feel about the statement.

- | | | | |
|--|-----|----|-----------|
| 1. I like school. | Yes | No | Sometimes |
| 2. I am doing well in school. | Yes | No | Sometimes |
| 3. I get in trouble with my teacher. | Yes | No | Sometimes |
| 4. I have self-confidence. | Yes | No | Sometimes |
| 5. I have tried to start fights with other kids. | Yes | No | Sometimes |
| 6. When I ask my parent(s) or the adults that take care of me a question, they usually listen. | Yes | No | Sometimes |
| 7. I talk about my thoughts and feelings with my father. | Yes | No | Sometimes |
| 8. I talk about my thoughts and feelings with my mother. | Yes | No | Sometimes |
| 9. When you break the law, you have to be punished. | Yes | No | Sometimes |
| 10. I have a parent or loved one who was/is in jail | Yes | No | |
| 11. I worry about what will happen to him/her while they are in jail. | Yes | No | Sometimes |
| 12. I know why they are in jail. | Yes | No | |
| 13. I was there when he/she was arrested. | Yes | No | |
| 14. I am mad at the police for arresting him/her. | Yes | No | Sometimes |
| 15. I feel like what happened to my family is my fault. | Yes | No | Sometimes |
| 16. I tell my friends about him/her being in jail. | Yes | No | Sometimes |
| 17. I feel like the only kid in the world who has a loved one in jail. | Yes | No | Sometimes |
| 18. Do you write letters/cards to them in jail? | Yes | No | Sometimes |
| 19. Do you talk to him/her on the phone? | Yes | No | Sometimes |
| 20. Does your loved one in jail write letters/cards to you? | Yes | No | Sometimes |
| 21. Do you visit him/her in jail? | Yes | No | Sometimes |
| 22. Do you miss your loved one that is in jail? | Yes | No | Sometimes |
| 23. Overall, how do you feel about what is happening in your family? | | | |

Mentee's signature

Date



Parent/Caregiver Application

Youth's Name: _____

Parent/Caregiver's Name: _____ Date: _____

Relationship to youth: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell Phone # _____

Best contact number: _____ May we text you? ___Yes___No

Email: _____

Sex: M F Birthdate: ___/___/_____ Race: _____

Primary Language: _____ Other Languages Spoken: _____

Please provide any employment information:

Name of Employer: _____ Work # _____

Please provide alternate contact numbers to reach you, only if we are unable to reach you with the telephone numbers listed above (friend, family member, neighbor)

Name: _____ Relationship: _____

Telephone Number: _____

Name: _____ Relationship: _____

Telephone Number: _____

Name: _____ Relationship: _____

Telephone Number: _____

I agree to allow Seton Youth Shelters to use the alternate telephone numbers to contact me, only if they are unable to reach me through my contact numbers. I understand that MCP staff will need to tell the alternate contacts the name of the staff member who is calling and the name of the agency.

Signature

Date

Please read this carefully before signing:

Seton Youth Shelters MCP Program appreciates you and your child's interest in his/her becoming a mentee. This application is intended as a means of informing and gaining the consent of the parent/guardian to allow their son/daughter to participate in the Seton Youth Shelters MCP Program.

After receiving this completed application from you, we will evaluate the information and send you a letter letting you know if your child has been accepted into the mentoring program. Much of the information you supply in this application packet will be used to match your child with an appropriate mentor. Therefore, the mentoring staff may, at times, need to access and share this information with prospective mentors and other parties when it is in the best interest of the match. However, we do not reveal names until there is an initial interest from the mentee, parent/guardian, and mentor based first upon anonymous information provided about each other.

Please initial each of the following:

_____ I give my informed consent and permission for my child to participate in the Seton Youth Shelters' MCP Program and its related activities.

_____ I agree to have my child follow all mentoring program guidelines and understand that any violation on my child's part may result in suspension and/or termination of the mentoring relationship.

_____ I hereby acknowledge that my child will be transported by his/her mentor and/or Seton Youth Shelters' staff or representatives while participating in the Seton Youth Shelters' MCP Program, and that such transportation is voluntary and at his/her own risk.

_____ I release the Seton Youth Shelters' MCP Program of all liability of injury, death, or other damages to me, my child, family, estate, heirs, or assigns that may result from his/her participation in the program, including but not limited to transportation, and hold harmless any Seton Youth Shelters mentor, program staff, or other representatives, both collectively and individually, of any injury, physical or emotional, other than where gross negligence has been determined.

_____ I attest that my child has been affected by incarceration.

_____ I understand that Seton Youth Shelters might host group events that my child may attend. I understand that it is my sole discretion whether or not my child may attend these outings as the Seton Youth Shelters' Mentoring Children of Prisoners name may be used at these group outings.

I understand I must return all of the *completed* items along with this application, and that any incomplete information will result in the delay of my application being processed.

By signing below, I attest to the truthfulness of all information listed on this application and agree to all the above terms and conditions.

Parent/Guardian Signature

Date

Family History

Biological Mother: _____

City & State: _____

Telephone Number: (H): _____ (C): _____

Biological Father: _____

City & State: _____

Telephone Number: (H): _____ (C): _____

Step/Adopted Mother: _____

City & State: _____

Telephone Number: (H): _____ (C): _____

Step/Adopted Father: _____

City & State: _____

Telephone Number: (H): _____ (C): _____

Siblings:

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

(Please use an additional sheet if more space is needed to list siblings)

Seton Youth Shelters Mentoring Program Medical History and Authorization for Emergency Medical Services

Child's Full Name: _____ **Age:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

DOB: _____ **Height:** _____ ft. _____ in. **Weight:** _____ lbs

Caregiver Name: _____ **Phone:** _____

Alternate Emergency Contact: _____ **Phone:** _____

Medical Insurance: _____ **Policy #:** _____

Primary Physician: _____ **Phone:** _____

Address: _____

Date of Last Physical Exam: _____

Mental Health Provider/Counselor:

Name: _____ **Dates From:** _____ **To:** _____

Agency: _____ **Phone:** _____

Address: _____

Dentist: _____ **Phone:** _____

Address: _____

Current Medications:

1.) **Prescription:** _____

2.) **Non-Prescription:** _____

Medical & Surgical History

Allergies (Food, Drugs, Pets, Other): _____

Current Medical Problems and Diagnoses (Mental Health and/or Physical): _____

Past and/or Present Infectious Diseases: _____

General Health Review: Indicate specific problems in the "Comment" section.

Cardiovascular ___ Yes ___ No Neurological ___ Yes ___ No

Respiratory ___ Yes ___ No Visual: Glasses ___ Yes ___ No

Musculoskeletal ___ Yes ___ No Contacts ___ Yes ___ No

Skin ___ Yes ___ No Auditory:

Stomach/Intestinal ___ Yes ___ No Hearing Aide ___ Yes ___ No

Genitourinary ___ Yes ___ No Oral/Dental ___ Yes ___ No

Speech ___ Yes ___ No

Special Needs/Conditions: _____

Family Medical History: Parents, Grandparents, Siblings, or Children

			WHO	
Diabetes	___ Yes	___ No		_____
Cancer	___ Yes	___ No		_____
Hypertension	___ Yes	___ No		_____
Heart Disease	___ Yes	___ No		_____
Tuberculosis	___ Yes	___ No		_____
Epilepsy	___ Yes	___ No		_____
Hepatitis	___ Yes	___ No		_____
STD	___ Yes	___ No		_____
Kidney	___ Yes	___ No		_____
Mental Illness	___ Yes	___ No		_____
Substance Abuse	___ Yes	___ No		_____ Type: _____
Other				_____

Child's Sexual History

Sexually Active: Y / N / Unk Children: Y / N History of STD: Y / N Type: _____
 History of Pregnancy: Y / N Miscarriage: Y / N Abortion: Y / N Current Pregnancy: Y / N / Unk

Child's Substance Abuse History:

Substance Abuse	Date of Onset	Frequency	Amount	Last Used
Nicotine				
Alcohol				
Marijuana				
Crack/Cocaine				
Ecstasy				
LSD				
PCP				
Other:				

Completed By: _____ **Date:** _____

Authorization to Initiate Emergency Medical Services

I/We, _____, authorize Seton Youth Shelters Mentoring Program Representative to initiate Emergency Medical Services for _____ in the event I cannot be contacted.

This document is to be presented to the physician/hospital/EMS Personnel as an indication of authorization for emergency medical services. This authorization is intended to relieve physician/hospital/EMS Personnel from any liability resulting from the failure of the legal guardian from signing a consent or authorization to render such care.

It is my understanding that this form also serves to establish my consent and permission for the above named minor to participate in Seton Youth Shelters Mentor Program.

	Date
Parent/Legal Guardian	Date
	Date
Seton Youth Shelters Representative	Date

**Please return or mail this application and the items listed above to Mentoring Program Director,
 Seton Youth Shelters, 101 N. Lynnhaven Rd., Suite 101 Virginia Beach Boulevard, Virginia Beach, Virginia
 23452.**