

# PROJECT C.O.P.E. MENTORING PROGRAM

## Mentee Application

(To Be Completed by the Parent/Guardian)

### Personal Information

Youth's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Relationship to Youth: Mother \_\_\_\_\_ Father \_\_\_\_\_ Other, specify: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Youth's Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender: Male \_\_\_\_ Female \_\_\_\_

Ethnicity: White: \_\_\_\_; Hispanic /Latino: \_\_\_\_; African American: \_\_\_\_; Asian: \_\_\_\_; Other: \_\_\_\_\_

Name of School: \_\_\_\_\_ Grade: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Please list all children in your household:

Name	Gender	Age	Does the child have an incarcerated parent? Yes or No

Name of incarcerated parent: \_\_\_\_\_

Relationship to the youth(s) (mother/father): \_\_\_\_\_

Prison and location: \_\_\_\_\_

SBI # \_\_\_\_\_

## Application Questions

Please answer the following questions as completely as possible. If more space is needed, use an extra sheet of paper or write on the back of this page.

1. Please describe any previous mentoring experiences your child has had, and how do you expect your child to benefit from the Project C.O.P.E. mentoring program? \_\_\_\_\_

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2. How has your child reacted to the incarceration of his or her parent? \_\_\_\_\_

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3. Describe your child's interests, hobbies, favorite activities. \_\_\_\_\_

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4. Describe your child's school performance (i.e. grades, homework, attendance, behavior, etc.) and specify areas that need improvement. Also, the behavior in the home. \_\_\_\_\_

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5. When is the mentee available for mentoring? (check all that apply) \_\_\_\_\_ Right after school

\_\_\_\_\_ After 5:00 p.m. \_\_\_\_\_ weekends \_\_\_\_\_ During the day (holidays and summer)

## HEALTH RECORD

*THIS CONFIDENTIAL HEALTH RECORD WILL ONLY BE USED TO ENSURE THE SAFETY OF THE CHILDREN IN THIS PROGRAM. THIS INFORMATION WILL NOT BE SHARED OUTSIDE OF THIS PROGRAM. FEEL FREE TO CONTINUE YOUR NOTES ON BACK OF THIS FORM.*

### 1. Please provide your child's medical history.

CONDITION	YES (if yes, write approx. date)	NO
Asthma	<input type="checkbox"/> _____	<input type="checkbox"/>
Convulsions/Seizures	<input type="checkbox"/> _____	<input type="checkbox"/>
Diabetes	<input type="checkbox"/> _____	<input type="checkbox"/>
Ear Infections	<input type="checkbox"/> _____	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/> _____	<input type="checkbox"/>
Measles	<input type="checkbox"/> _____	<input type="checkbox"/>
German Measles	<input type="checkbox"/> _____	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/> _____	<input type="checkbox"/>
Mumps	<input type="checkbox"/> _____	<input type="checkbox"/>
Corrective Device (glasses, hearing aid, etc.)	<input type="checkbox"/> _____	<input type="checkbox"/>
Does your child use an inhaler?	<input type="checkbox"/> _____	<input type="checkbox"/>

ALLERGY	YES	NO
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
Insect Stings	<input type="checkbox"/>	<input type="checkbox"/>
Foods	<input type="checkbox"/>	<input type="checkbox"/>
Plants	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
Topical ointments	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>

If "yes" to any of the above, please specify allergy and describe reaction.

### 2. List significant illnesses or surgeries. Provide the date and any instructions, if needed.

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### 3. Does your child have any special situations or needs that program staff and mentors should be aware of? Please describe below:

Child has behavioral/emotional difficulties: \_\_\_\_\_

Child has physical disabilities: \_\_\_\_\_

Other (describe): \_\_\_\_\_

### 4. Special Health Care Needs

Does your child have special health care needs that require treatment and/or medication?

YES  NO

If yes, describe below. If your child requires treatment and/or medication during the time they are being mentored, please describe their treatment below. \_\_\_\_\_

Does your child currently see a counselor or therapist?  YES  NO

### 5. Medical Emergency Information

Name of Primary Care Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Medical Insurance Provider: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Phone #: \_\_\_\_\_

### Permission to Participate

I, \_\_\_\_\_, the parent / guardian of \_\_\_\_\_, give permission for him/her to participate on the Project C.O.P.E. Mentoring Program. I have met with a caseworker to discuss my child's participation.

I understand that the people who serve as mentors in the Project C.O.P.E. Mentoring Program are adult volunteers from the community who have been carefully screened by the organization. The meetings between my child and the mentor will take place at various places in the community and at Project C.O.P.E. sponsored events. All contacts between the mentor and mentee will be monitored and evaluated by Center for Family Services employee. All contacts between the mentor and my child will be scheduled in advance. I reserve the right to withdraw my child from the program at anytime.

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