**Mill City Mentors**

**17 Kirk St.**

**Lowell, MA 01852**

**Tel. 978-654-5612**

**Fax (978) 654-5071**

The child's parent/guardian or another adult who has knowledge of the child's history and family should complete this application. **The child's parent or guardian must sign it**. Staff will review this application and you will be notified as to the next steps in the process. Please call our office at the above number if you need assistance in completing this form.

***(Please Print)***

***Child's Information***

**Child's Name**:

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  | (First) | |  |  |  | (M) | | | |  |  | (Last) | | | | |  |
| **Date of Birth**:\_\_/\_\_/\_\_ | | | | | |  | **Age**:\_\_\_\_\_\_\_\_ | | | | | | **Phone:** | | | | | | |  |
| **Child's Address**: | | | | | |  |  |  |  |  |  |  |  |  |  |  |  | **Apt.** | |  |
| **City** |  | | | | |  |  |  | **State** | | |  |  |  |  | **Zip** |  | | |  |
|  |  |  |  |  |  |  | ***Parent/Guardian Information*** | | | | | | | | | | | | |  |
| **Name:** | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  | (First) | |  |  |  |  |  |  |  | (Last) | | | | | | |  |
| **Date of Birth**: \_\_/\_\_/\_\_  **Work Phone:** | | | | | |  |  |  |  |  | **E-mail:** | | | | | | | | |  |
|  | | |  | | |  | | | | |  | |  |  |  |  |  |  |  |  |
| **May we call at work?** | | | | | | **Yes / No** | | | | | | |  |  |  |  |  |  |  |  |

**How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Referral Source: *social worker, therapist, teacher, etc.*** | | | | |  |  |
| **Name:** |  | | | **Phone** | **\_** | |
|  |  |  |  |  |  |  |
| **Child’s Race:** | |  |  |  |  |  |

**Does the child have a parent in state or federal prison? Yes / No**

**Please list any medical problems or allergies your child may have:**

**List everyone residing in the child's home, include names and ages.**

***Name*** ***Relationship to child*** ***Age***

(Continue on Back)

**Please explain why you would like a mentor for your child?**

**Have you talked to your child about this program? Yes** **No**

**If yes, how does he/she feel about being involved in the program?**

**Please list anything that we should consider in deciding who would be a suitable volunteer for your child.**

**Additional**

**Comments**:

**SIGNATURE OF PARENT/GUARDIAN** **DATE**

Parent/Guardians and children applying for this service must complete an intake process to decide on acceptability for this program. If the parent who does not live with the child sees the child regularly he or she must consent to the child receiving this service. I agree to allow staff and media representatives to take my photograph at MCM events. I understand that my name, photographs, and videos may be used to promote the mission of MCM.