**Youth Empowerment Mentoring Program**

*This form is to be completed and returned to* [*tyrone.curran@oasishendersonavenue.org*](mailto:tyrone.curran@oasishendersonavenue.org)*. Information will be kept confidential and will be used to assist staff in placing the referred young person in the Youth Empowerment Mentoring Program at Oasis Hub Henderson Avenue.*

**Young Persons Personal Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Surname: | Forename(s) | Title | Gender:   Female  Male  Other |
| Permanent Address: | | Date of Birth: | Age: |
| Home Contact No: | |
| Mobile Contact No: | |
| Nationality: | |
| Postcode: | | Ethnicity: | |
| School: | | Year: | |
| School Address:  Postcode: | | School Telephone Number: | |
| Email: | |

**Medical Details**

|  |  |
| --- | --- |
| Doctors/Surgery: | |
| Address: | Telephone Number: |
| Postcode: |  |

Do you take any medication that the Mentoring team should be aware of? If so, please give details below:

|  |
| --- |
| Medication: |

**DISABILITIES**

Oasis Youth Empowerment uses this information to provide you with any support you will require to fulfil your mentoring program.

Do you consider yourself to have a learning difficulty and/or disability and/or health problems?

(please tick on the boxes below)

|  |  |  |
| --- | --- | --- |
|  Yes |  No |  Prefer not to say |

If yes, please tick any relevant boxes and provide details if you wish:

|  |  |  |
| --- | --- | --- |
|  | Details | Guidance |
|  Developmental |  | Developmental – ADHD/ADD, Autistic Spectrum Disorder, Dyslexia, Dyspraxia |
|  Injury |  | Injury – Body, Brain |
|  Physical |  | Physical – Spina Bifida, Down’s Syndrome, Other |
|  Medical |  | Medical – Allergies, Arthritis, Asthma, Diabetes, Epilepsy, ME/Chronic Fatigue, Other |
|  Mental Health |  | Mental Health – Bipolar, Depression, Eating Disorder, Self-harm, Other |
|  Progressive |  | Progressive – Muscular Dystrophy, Other |
|  Sensory |  | Sensory – Hearing, Vision, Other |

Has the youth received or awaiting a CAMHS diagnosis? (please tick a box)

|  |  |  |
| --- | --- | --- |
|  Yes |  No |  Still awaiting to hear |

If Yes please could you give us some context:

|  |
| --- |
|  |

Has an Early help been actioned? (please tick a box)

|  |  |  |
| --- | --- | --- |
|  Yes |  No |  Still awaiting to hear |

If Yes please could you give us some context:

|  |
| --- |
|  |

What are the youth’s interest and/or hobbies?

|  |
| --- |
|  |

**Parent/ Guardian Details**

|  |  |
| --- | --- |
| 1.Name: | Relationship: |
| Address (if different from above):  Postcode | Home Telephone Number: |
| Mobile Number: |
| Work Number: |
| Email Address: |
| 2.Name: | Relationship: |
| Address (if different from above):  Postcode | Home Telephone Number: |
| Mobile Number: |
| Work Number: |
| Email: |

**Parent Permission**

To Nominate Youth to the Youth Empowerment Mentoring Program at Oasis Hub Henderson Avenue

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent/Guardian/Custodian (circle one)

of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, do hereby give permission for

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Referring School and School Staff representative to nominate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for participation in the School Based Mentoring

Program provided by Oasis Hub Henderson Aveniue.

Nominations to this program are given through written referral by school staff or other counselling professionals and require the release of academic, family, and social background of the youth to the Youth Empowerment program. I understand that there is no guarantee that my child will be accepted into the program after he/she has been nominated.

Signature of Parent or Guardian

Print your name Date

**School Referral Form**

**Referral Contact Information**

|  |  |
| --- | --- |
| Organization: | Date of Referral: |
| Name: | Telephone Number: |
| Address:  Postcode | Email: |

**Agencies currently working with the youth**

|  |  |
| --- | --- |
| Agency: | Contact Name: |
| Address:  Postcode | Telephone Number: |
| Email: |
| Postcode: | |
| Agency: | Contact Name: |
| Address:  Postcode | Telephone Number: |
| Email: |

**Past agencies that have worked with the youth:**

|  |  |
| --- | --- |
| Agency: | Contact Name: |
| Address: | Telephone Number: |
| Email: |
| Postcode: | |
| Agency: | Contact Name: |
| Address: | Telephone Number: |
| Email: |
| Postcode: | |

**Youth Behaviour in School** (Please tick all those that apply)

|  |  |
| --- | --- |
| Issues or behaviour patterns affecting the youth’s school success | |
|  | Low grades |
|  | Learning disability |
|  | Poor attendance |
|  | Poor peer relations |
|  | Aggressive/ Fighting |
|  | Defiant of authority/questioning rules |
|  | Disrupts classroom |
|  | Overly dependent on peers/ adults |
|  | Quiet/ Withdrawn |
|  | Experimentation with drugs/ alcohol |
|  | Destructive |
|  | Fearful/Anxious |
|  | Emotional outbursts |

**Known risk factors**

|  |  |  |
| --- | --- | --- |
| Include both past and present. Please select at least two. | | |
|  | Youth | Family |
| Academic Struggles |  |  |
| Delinquent Behaviour |  |  |
| Disability (DD, physical, learning) |  |  |
| Domestic Abuse |  |  |
| Legal Issues |  |  |
| Low Income |  |  |
| Mental Health Concerns |  |  |
| Poverty |  |  |
| Out of Home Placement |  |  |

**Any other details that would be helpful to know** (behavior, attendance, attainment etc.)

|  |
| --- |
|  |

**Description of current school experience:**

|  |
| --- |
|  |

**Description of current home experience:**

|  |
| --- |
|  |

**What strengths do you identify in the youth?**

|  |
| --- |
|  |

**Who does this student trust or go to for support (at school or home)?**

|  |
| --- |
|  |