

Central Montana Youth Mentee Application

Application due: September 23, 2022

PO Box 1053
Lewistown MT 59457
cmym@midrivers.com 406-535-8899



Date: _____ Returning Mentee? Y N Years in program _____

Student last name: _____ First name: _____ Middle Initial: _____

Nickname: _____ Age: _____ Birth date: _____ Gender: M F

Primary Address: _____

Teacher's name: _____ School: _____ Grade: _____

Primary household: information about adults where mentee lives

Name: _____ Relationship to mentee: _____

Address: _____

Hm. phone: _____ Cell: _____ Employer: _____ Wk.phone: _____

Email: _____ best way to contact: email home cell work text

Legal Guardian? Y N Would you be willing to help with mentor program events occasionally? Y N

Name: _____ Relationship to mentee: _____

Hm. phone: _____ Cell: _____ Employer: _____ Wk.phone: _____

Email: _____ best way to contact: email home cell work text

Legal Guardian? Y N Would you be willing to help with mentor program events occasionally? Y N

Second Household: Parents not residing with student

Name: _____ Relationship to mentee: _____

Address: _____ Legal Guardian? Y N

Hm. phone: _____ Cell: _____ Employer: _____ Wk.phone: _____

Email: _____ best way to contact: email home cell work text

Name: _____ Relationship to mentee: _____

Address: _____ Legal Guardian? Y N

Hm. phone: _____ Cell: _____ Employer: _____ Wk.phone: _____

Email: _____ best way to contact: email home cell work text

▪ My child is not available during these times and days:

▪ My child's interests include:

▪ My child does not enjoy:

▪ I would like my child to work on:

- Do you have a specific mentor you want to request? Name: _____
- Other special request (such as: male mentor only) or other requests to be considered in the matching process.

- Are there any special circumstances we need to know about, such as restraining orders, special needs or additional caregivers?

Medical Alert information: (allergies, asthma, etc)

Emergency Information: please list 2 local people other than yourself usually available during the school day who have agreed to care for and provide transportation for your student if they become ill and you cannot be reached:

Name: _____ relationship _____ phone _____

Name: _____ relationship _____ phone _____

Family doctor: _____ phone: _____

Emergency Medical Authorization: I understand that in the event of an accident or illness, every effort will be made to contact parent/guardian immediately. If parent/ guardian cannot be reached, I authorize the mentoring program authorities to obtain emergency care for my child.

Parent / Guardian signature: _____ date: _____

Permission and parent obligations. Please initial below:

- CMYMP prints photos online, in newspapers and other publications. CMYMP does not identify students by full name. *Do you give permission for CMYMP to use your child's photo* YES _____ NO _____

As a mentee parent I understand my obligations:

- To get my student to mentoring events as needed: _____
- To stay in touch with the mentor : _____
- To contact CMYMP if I have concerns or problems: _____
- That this partnership is from October to April and ends after the last group event: _____
- Attend planned trainings or events, monitor child's scheduled events and follow up with mentor and CMYMP if there are any changes that affect child's participation in the program. _____

The information provided on this form is true and accurate to the best of my knowledge as of this date.

Signature of legal guardian

Date

Please fill out this form and *return to your student's school office, CMYMP office or FHS office.* Make a copy to keep for your records and information.