



# OAKLAND COUNTY YOUTH ASSISTANCE PROGRAM REFERRAL FORM

PLEASE PRINT IN BLACK INK

Reason	Area	Staff
_____	_____	_____

Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ Parent / Guardian Email \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Asian  Black  Caucasian  Hispanic  Multi-racial

(w)  
(h)  
(cell)

Mother's Name \_\_\_\_\_ Address \_\_\_\_\_ City and Zip \_\_\_\_\_ Phone \_\_\_\_\_

(w)  
(h)  
(cell)

Father's Name \_\_\_\_\_ Address \_\_\_\_\_ City and Zip \_\_\_\_\_ Phone \_\_\_\_\_

(w)  
(h)  
(cell)

Step-parent or Guardian (living with child) \_\_\_\_\_ Address \_\_\_\_\_ City and Zip \_\_\_\_\_ Phone \_\_\_\_\_

Name of School \_\_\_\_\_ Grade \_\_\_\_\_ School District \_\_\_\_\_

Name of Local Youth Assistance Program \_\_\_\_\_

## BRIEF DESCRIPTION OF REASON FOR REFERRAL (use additional sheets if necessary)

Is LAW ENFORCEMENT involved with this referral? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, who? _____	Have other agencies or school services been involved? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, who? _____
Is parent aware of referral? Yes <input type="checkbox"/> No <input type="checkbox"/>	Is youth aware of referral? Yes <input type="checkbox"/> No <input type="checkbox"/>

Signature of Referring Person:     /     Date: \_\_\_\_\_

(automatic signature)

Print Full name of Referring Person: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ City and Zip Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Agency: \_\_\_\_\_