



In School Mentoring Program



Student Referral Form

Referral Source: Parent School Student

Name of Student:		Date:	
Address:		Postal Code:	
Parents/Guardian: Name:		Daytime Number:	Evening Number
Name:		Daytime Number:	Evening Number:
Student:	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Grade:
Teacher:		School:	
Teachers email address:		School Phone #	

When is your student available for help? (Please fill in the **exact times** below) i.e. 3:30 – 4:30 PM

	Monday	Tuesday	Wednesday	Thursday	Friday
School Time please be specific					
After School					

• Preference: Male volunteer Female volunteer Either would be fine

TO BE COMPLETED BY THE TEACHER/COUNSELOR:

- List the subjects and describe the skills/subject areas that the volunteer should focus on.

• Does this student have a behavioral disorder or diagnosed learning disability? No Yes if so explain:

• Any health concerns we should know about? Any other comments or concerns?