



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)

[Large empty box for description of reason for referral]

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: /s/ Date:

(automatic signature)

Print Full name of Referring Person: Email:

Address: City and Zip Code:

Telephone: Agency: