OAKLAND COUNTY YOUTH ASSISTANCE PROGRAM
REFERRAL FORM

Reason	Area	Staff

PLEASE PRINT IN BLACK INK

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 ☐ No ☐ If yes, who?	Have other agencies or school services been involved? Yes ☐ No ☐ If yes, who?
Is parent aware of referral? Yes ☐ No ☐	Is youth aware of referral? Yes ☐ No ☐

Signature of Referring Person: /s/ ____________________ **Date:** __________
(automatic signature)
Print Full name of Referring Person: ____________________ **Email:** __________
Address: ____________________ City and Zip Code: __________
Telephone: ____________________ Agency: __________