MENTORSHIP

Dear Parent,

Remember who BELIEVED in you.

Your school district believes that the path to success for all students starts with strong and lasting connections from a circle of invested adults. By partnering with community agencies committed to supporting our area youth, the Community Connector Consortium would like to offer the below listed programming to your child. In most cases, there is little or no cost for participation. With your consent, your child will establish a connection with a trained and certified adult dedicated to improving confidence, resiliency, achievement, conflict-resolution, and vocational readiness. Please complete the below information and return to your child's main office as soon as possible to begin programming.

CHILD'S NAME _____ Home Phone _____

Male / Female Address_____ _____ Date of Birth_____ Age_____

Grade_____

Team _____

Parent (legal guardian)
Name_____
Address_____
Home Phone_____
Cell_____
Work_____
Email_____

Parent
Name_____
Address_____
Home Phone_____
Cell_____
Work_____
Email_____

Emergency Contact
Name_____
Address_____
Home Phone_____
Cell_____
Work_____
Email_____

Your child has been invited to participate in the below program/s:

Please see attached details for programs checked

BEHAVIORAL HEALTH

__ Weekly Village Network Behavioral Health Support
__ OHuddle Case Management
__ Clinical Counseling

VOCATIONAL MENTOR

__ Vocational 1:1 Daily Mentoring
__ Drug Free Clubs of America
__Vocational Coach

INDIVIDUALIZED MENTOR

__ Afterschool Small Group Mentorship
__Multi-weekly healthy choice mentor
__Weekly engagement with a 1:1 mentor
__ OHuddle Case Management

SUMMER CAMP MENTORSHIP

__ OHuddle Day Camp
__BGC Day Camp

ACADEMIC MENTORSHIP

__ BGC Daily afterschool homework support & activities
__SOAR Executive Functioning Coaching

RECREATIONAL MENTORSHIP

__ Therapeutic Art Club
__Social Skills Drama Club
__Meditative Knitting Club

With questions, CONTACT

LYNETTE DUPLAIN,
Administrative Assistant
Cell: 330-345-6475 x7453
Mail to: OHuddle
PO Box 1296 Wooster
lduplain@ohuddle.org

Wooster City School District · The Village · Orrville City Schools · Akron Children's

Record Release

_____ Schools have permission to share information with the following agencies regarding: (Student name) _____

Shared information may include progress monitors, observational reports, medical information, demographic information, academic progress, and behavioral / social ratings.

__ OHuddle Youth Program
__Boys and Girls Club of _____
__Salvation Army
__Camp _____
__OneEighty
__Fiat / Anazao
__Cleveland Clinic / Milltown Physicians / Akron Children's Hospital
__Behavioral Health Support: The Village Network, Counseling Center, Catholic Charities, ___,
__Service Coordination: Tri County
__Other_____

Signature of Parent / Guardian
X_____
Date_____
Parents have a right to withdraw consent at any time and can do so in writing to the attention of L. Duplain

PROGRAM PARTICIPATION AUTHORIZATION

My Child _____ has permission to participate in the above listed activities at _____ School and in the surrounding community. I permit my child to travel to and from activities by van / bus or my own transport. My child is responsible for his / her conduct by following all group rules and regulations. OHuddle and the above agencies will not assume any liability. I also consent for my child to be photographed for programming features unless otherwise noted.

Signature of Parent / Guardian
X_____
Date_____
Parents have a right to withdraw consent at any time and can do so in writing to the attention of L. Duplain

EMERGENCY MEDICAL AUTHORIZATION

Purpose: to enable parents and guardians to authorize the provision of emergency treatment to children who become ill or injured while under mentor supervision, when parents or guardians cannot be reached.

In the event of injury or illness, I hereby give consent for the team to access medical treatment for my child.

Signature of Parent / Guardian
X_____
Date_____
Parents have a right to withdraw consent at any time and can do so in writing to the attention of L. Duplain

The image part with relationship ID rId9 was not found in the file.

MEDICAL CONTACTS

List only the names of the individuals who have the authority to make decisions in an emergency situation regarding your child:

1st:_____
phone_____

2nd_____
phone_____

PREFERRED PHYSICIAN

_____
phone_____

LIST ANY MEDICATION / HEALTH ISSUES_____
_____
_____
_____