

Sunflower Bakery Application
Summer Sessions at Sunflower 2017

Please provide all information requested, indicating NA where not applicable. Select one session from the following:

1-3:30 p.m. June 26-June 30 July 10-14 July 17-21 July 24-28

STUDENT INFORMATION

Participant's Name: _____ Nick Name: _____

Sex: Male Female Date of Birth: _____ Age: _____

Address _____ City _____ State _____ Zip _____

Present Living Arrangements: (Check one)

With family

First parent name: _____ Email _____

Phone: Home _____ Day: _____ Cell: _____

Second parent name: _____ Email _____

Phone: Home: _____ Day: _____ Cell: _____

OR

With legal guardian

First guardian name: _____ Relationship _____ E-mail: _____

Home phone: _____ Day: _____ Cell: _____

Second guardian name: _____ Relationship _____ E-mail: _____

Home phone: _____ Day: _____ Cell: _____

Teen's disability/ies (Please describe.): _____

Mobility: Ambulatory Personal Care: Independent

Communication: Verbally Yes No If no, what means/methods are used to communicate? What assistive devices used to communicate will be brought to class?

Provide any additional information pertinent to applicant's expressive or receptive language.

SCHOOL ATTENDING:

Please list school, specifying middle or high school attending and dates as requested.

School Name	Phone/email	Dates attended	Expected grad. Date	Certificate or diploma?
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Please attach current IEP, including goals, progress towards goals, and accommodations.

Previous camp or summer experiences in past 3 years (include ESY):

Name	Type of program	Address	Dates
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Is applicant able to read? ___ yes ___ no. If yes, at what grade level? _____

Has applicant had any experience cooking or baking at home? ___yes ___no

Can applicant stand for 2-1/2 hours while preparing and baking? ___Yes ___No

Please indicate skill level for the list below. Please rate as follows for each skill:

T= Tried, NT= Never Tried, C = Capable, E = Excellent

Identifies ingredients___ Identifies utensils ___ Washes dishes ___

Measures with measuring cups ___ Measures with measuring spoons ___

Understands need to wash hands ___ Uses whisk ___ Uses spatula ___

Turns oven off/on ___ Uses microwave ___

Uses electric hand mixer ___ Uses food processor ___

Uses electric stand mixer ___ Ties apron independently ___

Removes pans from oven ___

Consistently identifies and differentiates sizes of measuring cups ___ and spoons ___

Please check appropriate spaces that best describe applicant's disability/disabilities.

___ Learning Disability

___ Behavior problems

___ Mild intellectual disability

___ Attention deficit hyperactivity disorder

___ Moderate intellectual disability

___ Anxiety disorder

___ Epilepsy/seizure disorder

___ Hearing loss

___ Cerebral palsy

___ Limited vision

___ Limited mobility

___ Speech/language impairment

___ Autism spectrum disorder

___ Psychiatric diagnosis/mental illness

___ Depression

___ Other

Is applicant currently taking any medications for any of the above? ___yes ___no If yes, which medications?

*Psychiatric/Psychological/Emotional Disability

Primary Diagnosis _____

Additional Diagnoses _____

Please attach a copy of the most recent psychological evaluation results.

Please comment on any of above with regard to educational settings. Please indicate any restrictions from participation in Bakery activities. Use back of page if necessary.

BEHAVIORAL CONCERNS:

Does applicant (check if yes)

Threaten to do physical violence ___

Ignore or resist following instruction or routines ___

Damage personal property ___

Lie or steal ___

Damage the property of others ___

Abuse self ___ Abuse substances ___

Damage public property ___

Have a record of any arrests ___

Use angry language ___

Have socially unacceptable sexual habits ___

Have violent temper or temper tantrums ___

Exhibit offensive behavior with peers ___

Please comment on any of above with regard to educational settings:

EMERGENCY CONTACTS

Emergency contact #1 Name: _____ Relationship: _____
Day phone: _____ Cell phone: _____ e-mail _____
Emergency contact #2 Name: _____ Relationship: _____
Day phone: _____ Cell phone: _____ e-mail _____
Emergency contact #3 Name: _____ Relationship: _____
Day phone: _____ Cell phone: _____ e-mail _____

At the end of class, I authorize the following people to pick up my child from Sunflower Bakery with ID:
(You should inform anyone whose name is listed. List yourself and include 2 others' names and cell phones.)

HEALTH AND MEDICAL INFORMATION

Name of Primary Physician: _____ Telephone number: _____
FAX: _____
Name of Psychiatrist/Therapist/Counselor (if applicable): _____
Telephone number: _____
Name of Dentist: _____ Telephone number: _____
Medical insurance covered by (company name): _____ Group: _____
Governmental Program: _____ Policy number: _____
Allergies: _____
Date of last Tetanus shot: _____
History of gluten intolerance or Celiac disease? ___yes ___no
Medical concerns: _____

Medical Release

The applicant has permission to participate in all Sunflower Bakery activities except as noted by me. I give permission to the physician selected by Sunflower Bakery to order x-rays, routine tests, and treatment related to the health of the participant for emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this applicant. I understand the information on this form will be shared on a "need to know" basis with Bakery staff. I give permission to photocopy this form. In addition, the Sunflower Bakery has permission to obtain a copy of the applicant's health record from providers who treat him/her and these providers may talk with the Bakery's staff about the applicant's health status.

Date: through July 28, 2017

Signature of parent/guardian

Photo or Video Image Release

I give my permission and consent to allow my son's/daughter's photographs or video image to be taken during Sunflower Bakery activities. I further give permission and consent that any such photographs or video image may be published and used by Sunflower Bakery and its agents, to illustrate and promote the Bakery.

Signature of custodial parent/guardian

Release of Liability

The participant assumes all risks associated with participation in the class(es). Sunflower Bakery assumes no liability for injury or damages arising from participation in the class(es).

Other Releases

I hereby give permission to the professionals listed below to release information that would relate to my child's participation in classes with the Sunflower Bakery. This would include diagnoses, treatment summaries, test results, behavior management programs, verbal exchanges between treating persons or facilities, and any other information or recommendations considered pertinent to this relationship.

_____ Date: March 2017 through July 28, 2017

Signature of parent/guardian

Please list any therapists with whom the applicant may be currently involved.

Name	Title	Agency	Address	Phone	E-mail
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Agreement

I agree to pay fees of \$375 per week attending. (Payment required at time of interview.)

Signed _____ Date _____
Parent or Guardian

HOW DID YOU FIND OUT ABOUT SUNFLOWER BAKERY? _____

HAVE YOU MET WITH ANYONE FROM THE DIVISION OF REHABILITATION SERVICES? ____ YES ____ NO
DO YOU HAVE A DORS COUNSELOR? ____ YES ____ NO IF SO, WHO? _____

PLEASE RETURN THIS FORM TO:
SUNFLOWER BAKERY, 8507 Ziggy Lane, Gaithersburg, MD 20877

ATTENTION:
SARA PORTMAN MILNER, LCSW-C
OR E-MAIL TO sara@sunflowerbakery.org
Phone: 240-361-3698