

Sunflower Bakery Application

Summer Teen Baking Exposure Program 2019

Please provide all information requested below.

Students will be accepted on a first-come, first-served basis. There will be two levels of classes, one for beginning students and one for those returning. Returning students may request to take the Level 1 class again. (DORS will not fund re-taking Level 1, if you participate in Pre-ETS.)

Students who wish to take Level 1 and returning students who wish to repeat Level 1:

Select your 1st, 2nd and 3rd choices of Level 1 sessions below:

Classes will meet from 1:30-4:00 p.m. daily, Monday through Friday.

Level 1

Waitlist Only ___ July 8-12 **Waitlist only** ___ July 15-19 **Waitlist only** ___ July 22-26 **Waitlist only** ___ July 29-Aug. 2

Students who wish to take Level 2 (Must have already taken Level 1):

Level 2 NA June 24-28th **LEVEL 2 PROGRAM IS FULL FOR 2019**

STUDENT INFORMATION

Participant's Name: _____ Nick Name: _____

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

Address _____ City _____ State _____ Zip _____

Present Living Arrangements: (Check one)

___ With both parents ___ With Mother ___ With Father

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: _____

SCHOOL ATTENDING:

Please attach current IEP, including goals, progress towards goals, and accommodations to this application.

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

| School name | Phone/email | Dates attending | Expected grad. date | Certificate or diploma track? |
|-------------|-------------|-----------------|---------------------|-------------------------------|
| | | | | |

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

| Name | Type of program | Address | Dates |
|------|-----------------|---------|-------|
| | | | |

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 ___ | | |

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.

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

- | | |
|---|---|
| <input type="checkbox"/> Learning disability | <input type="checkbox"/> Behavioral concerns |
| <input type="checkbox"/> Mild intellectual disability | <input type="checkbox"/> Attention deficit hyperactivity disorder |
| <input type="checkbox"/> Moderate intellectual disability | <input type="checkbox"/> Anxiety disorder |
| <input type="checkbox"/> Epilepsy/seizure disorder | <input type="checkbox"/> Hearing loss |
| <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Limited vision |
| <input type="checkbox"/> Limited mobility | <input type="checkbox"/> Speech/language impairment |
| <input type="checkbox"/> Autism spectrum disorder | <input type="checkbox"/> Psychiatric diagnosis/mental illness |
| <input type="checkbox"/> Depression | <input type="checkbox"/> 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 picture 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.

Signature of parent/guardian Date: January 2019 through December 31, 2019

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 Date: January 2019 through December 31, 2019

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).

Signature of parent/guardian Date: January 2019 through December 31, 2019

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: January 2019 through December 31, 2019
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 understand that the tuition for the Summer Program is \$541. I agree that if I am participating with DORS in Pre-ETS, I will follow up to ask DORS for Authorization for funding for the Sunflower Summer Teen Exposure Program. If DORS' Pre-ETS is not an option, I agree to pay \$541 by the first day of class.

Attached is my child's current IEP, including goals, progress towards goals, and accommodations.

Signed _____ Date _____
Parent or Guardian

PLEASE INDICATE STUDENT'S T-SHIRT SIZE: ___ Small ___ Medium ___ Large ___ Extra-Large ___ XXL

HOW DID YOU FIND OUT ABOUT SUNFLOWER BAKERY? _____

HAVE YOU MET WITH ANYONE FROM THE MD DIVISION OF REHABILITATION SERVICES (DORS)? ___ YES ___ NO

IF IN VIRGINIA, Department of Aging and Rehabilitative Services? ___ YES ___ NO

IF IN DC, Rehabilitation Services Administration? ___ YES ___ NO

DO YOU HAVE A DORS OR OTHER COUNSELOR FROM ONE OF THE ABOVE REHABILITATION SERVICES? ___ YES ___ NO

IF SO, WHO AND AT WHICH OFFICE?

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