

Sunflower Bakery Application
After School Teen Baking Exposure Program 2018-19

Please provide all information requested, indicating NA where not applicable.
Check here if you wish to be considered for _____ October

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 attending	Expected grad. Date	Certificate or diploma track?
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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 Behavioral concerns
- 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.

Signature of parent/guardian

Date: January 2019 through August 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 August 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).

Date: January 2019 through August 31, 2019

Signature of parent/guardian

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 August 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 After School Teen Exposure Program. If DORS' Pre-ETS is not an option, I agree to pay \$541 by the first day of class.

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 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