Sunflower Bakery Application

After-School Teen Baking Exposure Program 2020

Please provide all information requested below.
Students will be accepted on a first-come, first-served basis. The Level 1 classes offered here are usually funded by DORS for students who are registered in their Pre-Employment Transition Services program. (There will be additional classes offered at both Levels I and II later this winter and spring.)

Each class will meet one day each week from 4-6:30 p.m. for 5 weeks in a row. Register for only 1 below:
_____Level I begins Monday Jan. 27 to Monday Feb. 24 _____Level I begins Tuesday Jan. 28 to Tues.,Feb.25
_____Level I begins Monday, March 16 to Mon.,April 27 _____Level I begins Tuesday, March 17 to Tues.,April 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 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 Pre-ETS experiences:

Name of class/program	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.

____Learning disability
____Mild intellectual disability
____ Moderate intellectual disability
____ Epilepsy/seizure disorder
____ Cerebral palsy
____ Limited mobility
____ Autism spectrum disorder
____Depression
____ Behavioral concerns
____ Attention deficit hyperactivity disorder
____ Anxiety disorder
____Hearing loss
____ Limited vision
____ Speech/language impairment
____ Psychiatric diagnosis/mental illness
____ 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 ____
Damage personal property ____
Damage the property of others ____
Damage public property ____
Use angry language ____
Have violent temper or temper tantrums ____
Ignore or resist following instruction or routines ____
Lie or steal ____
Abuse self ____
Abuse substances ______
Have a record of any arrests ____
Have socially unacceptable sexual habits ____
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.

____ Date: January through June 2020
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.

____ Date: January through June 2020
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).

____ Date: January through June 2020
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 through June 2020

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 After-School 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 (ASTEP). 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

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 BY DECEMBER 30 TO:

SUNFLOWER BAKERY, 5951 Halpine Road, Rockville, MD 20852

ATTENTION:

SARA PORTMAN MILNER, LCSW-C

OR E-MAIL TO sara@sunflowerbakery.org

Phone: 240-361-3698