Sunflower Bakery Application

Summer Teen Baking Options 2020

Please provide all information requested below. Students will be accepted on a first-come, first-served basis.

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

Guardian name: _____Relationship_____ E-mail: _____

Home phone: _____ Day: _____Cell: _____

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?

How did you find out about Sunflower Bakery? _____

_____

My son/daughter would like to participate in the following:

1-week Summer Teen Exposure session at Sunflower Bakery, accompanied by a helper $375 /week_____

At-home Sunflower Kitchen Lab, available beginning July 6th $225/5 lessons_____

1-week session at Sunflower AND At-home Kitchen Lab. $575 package_____

For At-home Kitchen Lab, please select one week: July 6 ___ July 13 ___ July 20 ___
July 27 ___ August 3___ August 10 ___ August 17 ___

I understand I will be called by Janis from Sunflower Bakery in order to process my payment of $225 by charge and that my teen's request for the At-home Kitchen Lab will not be entered until the charge process has been completed.

Parent or Guardian _____ Date _____

Best phone number for charge_____

If registering ONLY for At-home Kitchen Lab, please sign above and return just this page.

QUESTIONS OR CONCERNS? EMAIL sara@sunflowerbakery.org

PLEASE RETURN THIS PAGE TO:

SUNFLOWER BAKERY

ATTENTION: SARA PORTMAN MILNER, LCSW-C

5951 Halpine Road, Rockville, MD 20851

OR E-MAIL to sara@sunflowerbakery.org

To Register for Summer Teen Baking Class, please continue on to next page.

For **Summer Teen Baking Class**, please select your 1st, 2nd and 3rd choices for a one-week session below:
Classes will meet from 1:30-3:30 p.m. daily, Monday through Friday. Three students will be admitted per class.
July 13-17 ____ July 20-24 ____ July 27-31 ____ August 3-7 ___ August 10-14 ___

ADDITIONAL INFORMATION NECESSARY:

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

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.

____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 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: July 6 through December 31, 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: July 6 through December 31, 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: July 6 through December 31, 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: July 6 through December 31, 2020

Signature of parent/guardian

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

Name Title Agency Address Phone E-mail

_____

_____

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

HAVE YOU MET WITH ANYONE FROM THE MD DIVISION OF REHABILITATION SERVICES (DORS)? ____ YES ____ NO
If so, with whom in which office? _____
IF IN VIRGINIA, Department of Aging and Rehabilitative Services? _____YES _____ NO
IF IN DC, Rehabilitation Services Administration? _____YES _____ NO

I understand I will be called by Janis from Sunflower Bakery in order to process my payment of $375 for the Summer Teen Baking Class or $575 for the Class and At-home package by charge, and that my teen's request for either will not be entered until the charge process has been completed.

Parent or Guardian _____ Date _____
Best phone number for charge_____

Signed _____ Date _____
Parent or Guardian

QUESTIONS OR CONCERNS? EMAIL sara@sunflowerbakery.org

PLEASE RETURN THIS 4-PAGE APPLICATION TO:
SUNFLOWER BAKERY
ATTENTION: SARA PORTMAN MILNER, LCSW-C
5951 Halpine Road, Rockville, MD 20851
OR E-MAIL to sara@sunflowerbakery.org