

Sunflower Bakery Application

Summer Teen Exposure Program 2021

Please provide all information requested below. Students will be accepted on a first-come, first-served basis. In order to ensure safety from COVID-19, all students must be at least 16 years old and wear masks. We strongly encourage all eligible participants to be fully vaccinated at least 2 weeks before the starting date for session attending.

Summer sessions for STEP 2021 will vary. The curriculum will be the same for all sessions. There will be three 1-week session options and two 5-week, once-a-week session options. Select your 1st, 2nd and 3rd choices of sessions below:

Session I: June 21-June 25th - 1:30-4 p.m. daily, Monday through Friday.

Session II: June 28-July 2nd - 9:30a.m.-12 noon daily, Monday through Friday.

Session III: June 28-July 2nd - 1:30-4 p.m. daily, Monday through Friday.

Session IV: July 12th, 19th, 26th, August 2nd, and 9th - 5-week class on consecutive Mondays, 9:30a.m.- 12 noon.

Session V: July 9th, 16th, 23rd, 30th and August 6th - 5-week class on consecutive Fridays, 1:30-4pm.

STUDENT INFORMATION

Participant's Name: _____ Nick Name: _____
 ___ Male ___ Female ___ Non-Binary 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 2 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 ___
- Measures with measuring cups ___
- Understands need to wash hands ___
- Turns oven off/on ___
- Uses electric hand mixer ___
- Uses electric stand mixer ___
- Removes pans from oven ___
- Consistently identifies and differentiates sizes of measuring cups ___ and spoons ___
- Identifies utensils ___
- Measures with measuring spoons ___
- Uses whisk ___ Uses spatula ___
- Uses microwave ___
- Uses food processor ___
- Ties apron independently ___
- Washes dishes ___

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: June 2021 through May 31, 2022

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: Date: June 2021 through May 31, 2022

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: Date: June 2021 through May 31, 2022

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: June 2021 through May 31, 2022
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

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, 5951 Halpine Road, Rockville, MD 20851

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