

Sunflower Bakery Application

Sunflower Teen Exposure Program 2023-24

Please provide all information requested below. **Students will be accepted on a first-come, first-served basis for each session.** In order to ensure safety and to protect from COVID-19, all students must be at least 16 years old and fully vaccinated at least 2 weeks before the starting date for session attending, or have an approved medical or religious exemption.

There will be 8 sessions offered between July 2023 and next June 2024. The curriculum will be the same for all sessions. **All SUMMER sessions will meet four consecutive days, Mondays-Thursdays from 3:00-5:30pm. The other sessions will meet for four consecutive Sunday afternoons from 12:30-3pm.** Select your 1st, 2nd and 3rd choices of sessions below:

<input type="checkbox"/> Session 1 July 10-13 FULL	<input type="checkbox"/> Session 5 Oct. 15, 22, 29, Nov. 5 Sundays
<input type="checkbox"/> Session 2 July 17-20	<input type="checkbox"/> Session 6 January 7, 14, 21, 28, 2024 Sundays
<input type="checkbox"/> Session 3 July 24-27	<input type="checkbox"/> Session 7 February 18, 25, March 3, 10, 2024 Sundays
<input type="checkbox"/> Session 4 July 31-Aug. 3	<input type="checkbox"/> Session 8 June 24-27, 2024

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?
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Previous camp or summer experiences in past 2 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 ____		

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/ies	<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/Blind
<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.

Date: July 2023 through June, 2024

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 2023 through June, 2024

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 2023 through June, 2024

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 2023 through June, 2024

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 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 teens@sunflowerbakery.org

Phone: 240-361-3698