

# 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. **Students may register for only ONE session each fiscal year.** Sessions beginning in October through February will meet for four consecutive Sunday afternoons from 12:30-3pm. **The JUNE 2024 session will meet four consecutive days, Mondays-Thursdays from 3:00-5:30pm.** Sessions marked as ~~Session~~ are no longer available. Select your 1<sup>st</sup>, 2<sup>nd</sup> and 3<sup>rd</sup> choices of sessions available below:

- |   |   |
|---|---|
| <input type="checkbox"/> Session 1 July 10-13     | <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?

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 \_\_\_
- 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/ies
- \_\_\_ Behavioral concerns
- \_\_\_ Mild intellectual disability
- \_\_\_ Attention deficit hyperactivity disorder
- \_\_\_ Moderate intellectual disability
- \_\_\_ Anxiety disorder
- \_\_\_ Epilepsy/seizure disorder
- \_\_\_ Hearing loss
- \_\_\_ Cerebral palsy
- \_\_\_ Limited vision/Blind
- \_\_\_ 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 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](mailto:teens@sunflowerbakery.org)  
Phone: 240-361-3698