Sunflower Bakery Application
Sunflower Teen Exposure Program (STEP) 2024-25

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 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 2024 and next June 2025. The curriculum will be the same for all sessions. All SUMMER sessions will meet four days of the week, Mondays, Tuesdays and Thursdays from 4:00-6:30pm and Fridays from 1-3:30pm. (We will skip Wednesdays.) The other sessions will meet for two consecutive weeks on Monday and Tuesday afternoons from 4:00-6:30pm, for a total of 4 classes. Please select your 1st, 2nd and 3rd choices of sessions below:

Following sessions meet 4-6:30pm M, T, Th and 1-3:30pm Fridays:

___Session 1 July 8, 9,11,12
___Session 2 July 15, 16,18,19
___Session 3 July 22,23,25,26
___Session 4 July 29, 30, Aug.1, 2

Following sessions meet 4pm-6:30pm each day:

___Session 5 September 9-10, 16-17
___Session 6 October 28-29, Nov. 4-5
___Session 7 November 11-12, 18-19
___Session 8 December 2-3, 9-10

STUDENT INFORMATION

Participant's Name: ____ *Preferred Name:* ________________
__Male __Female __Non-Binary Preferred pronouns: _________________Date of Birth: _____________Age: __
Select one of the following categories: Asian __ Black or African American__ Hispanic or Latino __ White __ Native American or Alaska Native __ Native Hawaiian or Other Pacific Islander__ Prefer not to say__
Address____City__________________________State______Zip______
Present Living Arrangements: (Check one)
___With both parents ___With Mother ___With Father ___With other
First parent name:____________________________________Email_______________________________________
Phone: Home _________________________Day:_______________________ Cell: ________________________
Second parent name: ____________________________________Email_____________________________________
Phone: Home: _________________________Day:_______________________ Cell: _________________________
OR ___With legal guardian(s), other
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.
Below, please name current school attending, specifying middle or high school, and dates as requested.

School name	Dates attending	Expected grad. Date	___ Certificate or __ Diploma?

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. (No prior experience necessary.) 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 digital kitchen scale___
Turns oven off/on ___ Uses spatula ___
Uses electric hand mixer ___ Uses food processor ___
Uses electric stand mixer ___ Ties apron independently ___
Removes pans from oven ___ Uses microwave ___
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
____ Speech/language impairment ____Hearing loss
____ Cerebral palsy ____ Limited vision/Blind
____ Limited mobility ____ Psychiatric diagnosis/mental illness
____ Autism spectrum disorder ____Depression
____ Chronic medical condition ____OCD
____ Epilepsy/seizure disorder Date of last seizure ___________ Motor or non-motor?__________________
____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 ____ Have difficulty with authority figures ____
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 outbursts ____ Exhibit offensive behavior, including bullying, with peers ____

Please comment on any of above with regard to educational settings:
____
____
Sunflower Bakery provides a safe environment. I agree that while I am at Sunflower Bakery, I will not engage in violence, threats of violence, threats of harm to self or others, damage to property, stealing, substance abuse, bullying, etc.
Signature of Applicant: ____
Signature of Parent/Guardian:____
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(s) of Psychiatrist/Neurologist (if applicable): _____________________________________
Telephone number(s) 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 2024 through June, 2025
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 2024 through June, 2025
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 2024 through June, 2025

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 2024 through June, 2025

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 Sunflower Teen Exposure Program (STEP) 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. **I understand that payment or Authorization for payment from DORS or another source must be received by Sunflower one full week before the first day of class attending.**

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

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