

# Sunflower Bakery Application

## Sunflower Teen Exposure Program (STEP) 2025

Please provide all information requested below. All students must be at least 16 years old

There will be 4 sessions offered the last 4 weeks of July 2025.\* The curriculum will be the same for all sessions. Each session will meet on Monday, Tuesday, Wednesday and Thursday afternoons from 3:30pm-6pm, for a total of 4 classes. *Students will be accepted on a first-come, first-served basis for each session.*

Please select your 1st, 2nd and 3rd choices of sessions below.

Following sessions meet 3:30pm-6:00pm each day:

\_\_\_ Session 1 July 7th - 10th  
\_\_\_ Session 2 July 14th - 17th

\_\_\_ Session 3 July 21st - 24th  
\_\_\_ Session 4 July 28th - 31st

**\*A new schedule of classes for the school year will be available in the summer.**

### 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
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	___ Certificate or ___ Diploma?
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Previous camp experiences or Pre-ETS classes 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. (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.

<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"/> Speech/language impairment	<input type="checkbox"/> Hearing loss
<input type="checkbox"/> Cerebral palsy	<input type="checkbox"/> Limited vision/Blind
<input type="checkbox"/> Limited mobility	<input type="checkbox"/> Psychiatric diagnosis/mental illness
<input type="checkbox"/> Autism spectrum disorder	<input type="checkbox"/> Depression
<input type="checkbox"/> Chronic medical condition	<input type="checkbox"/> OCD
<input type="checkbox"/> Epilepsy/seizure disorder	Date of last seizure _____ Motor or non-motor? _____
<input type="checkbox"/> Needs 1:1 Support	<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 ____ 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, 2025 through Dec., 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, 2025 through Dec., 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, 2025 through Dec., 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, 2025 through Dec., 2025

Signature of parent/guardian

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

Name	Title	Agency	Address	Phone	E-mail
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_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

### Agreement

I understand that the tuition for the Sunflower Teen Exposure Program (STEP) is \$700. 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 \$700. **I understand that payment or Authorization for payment from DORS or another source must be received by Sunflower two full weeks before the first day of class attending.**

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

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 BY EMAIL TO:

[teens@sunflowerbakery.org](mailto:teens@sunflowerbakery.org)

or by postal service mail or in person to:

SUNFLOWER BAKERY, 5951 Halpine Road, Rockville, MD 20851

ATTENTION:

SARA PORTMAN MILNER, LCSW-C

Phone: 240-361-3698