Sunflower Bakery Application
Sunflower Teen Exposure Program (STEP) 2025-26

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

There will be 6 sessions offered between Oct. 2025 and June 2026. The curriculum will be the same for all sessions. Each session, the classes will meet on Mondays and Tuesdays from 4-6:30PM, for two consecutive weeks. 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.

The following sessions from October through June will meet from 4-6:30 each day:

___ Session 4 Oct. 20-21, 27-28 ___ Session 5 Nov. 3-4, 10-11 ___ Session 6 Dec. 8-9, 15-16

___Session 7 Jan. 5-6, 12-13 ___ Session 8 Mar. 16-17, 23-24 ___ Session 9 June 22-23, 29-30

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-code: _____

Present Living Arrangements: (Check one)

___ Both parents ___ Mother __Father ___ Other

Guardian name: _____ Relationship: _____

Home Phone: _____ Cell: _____

E-mail: _____

Guardian name: _____ Relationship: _____

Home Phone: _____ Cell: _____

E-mail: _____

SCHOOL ATTENDING:

Please attach current IEP, including goals, progress towards goals, and accommodations to this application.

Name of current school: _____

____ Middle School _____ High School

Dates attending: _____Expected grad. Date: _____ Certificate or Diploma: _____

Previous camp experiences or Pre-ETS classes in past 2 years (include ESY):

Name Type of program: _____ Dates:_____

Address: _____

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 ____ 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 ____ Identifies utensils ____ Measures with measuring spoons ____ Uses whisk ____

Uses spatula ____ Uses food processor ____ Ties apron independently ____ Uses microwave ____

Washes dishes ____ Uses digital kitchen scale ____

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? _____

Will assistive devices need to be used to communicate in sessions? If so, what kind _____

Any additional information regarding applicant's expressive or receptive language: _____

_____

Please check appropriate spaces that best describe applicant's disability/disabilities.

___ Learning disability/ies

___ Mild intellectual disability

___ Moderate intellectual disability

___ Speech/language impairment

___ Cerebral palsy

___ Limited mobility

___ Autism spectrum disorder

___ Depression

___ Needs 1:1 support

___ Behavioral Concerns

___ Attention deficit hyperactivity disorder

___ Anxiety disorder

___ Hearing loss

___ Limited vision/Blind

___ Psychiatric diagnosis/mental illness

___ Chronic medical condition

___ OCD

___ Other: _____

___ Epilepsy/ seizure disorder Date of last seizure: _____ Motor or Non- motor? _____

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

___ Lie or steal

___ Have difficulty with authority figures

___ Damage public property

___ Have violent temper or outbursts

___ Have socially unacceptable sexual habits

___ Ignore or resist following instruction or routines

___ Damage the property of others

___ Abuse self

___ Abuse substances

___ Use angry language

___ Have a record of any arrests

___ 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.

Signature of parent/guardian: _____ Date: Oct.2025 through June 2026

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.

Signature of custodial parent/guardian: _____ Date: Oct.2025 through June 2026

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).

Signature of parent/guardian: _____ Date: Oct.2025 through June 2026

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.

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

Name:_____ Title: _____

Agency: _____ Phone: _____ E-mail: _____

Address:_____

Signature of parent/guardian: _____ Date: Oct.2025 through June 2026

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.

Parent or Guardian signature: _____ Signed Date _____

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

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