

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

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

The March session classes will meet on four consecutive Sundays, March 8, 15, 22, 29th from 1-3:30PM. Students will be accepted on a first-come, first-served basis for each session.

**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: \_\_\_\_\_

Home phone: \_\_\_\_\_

**Present Living Arrangements: (Check one)**

\_\_\_\_ Both parents \_\_\_\_ Mother \_\_\_\_ Father \_\_\_\_ Other

First parent name: \_\_\_\_\_ Email: \_\_\_\_\_ Cell: \_\_\_\_\_

2nd Parent name: \_\_\_\_\_ Email: \_\_\_\_\_ Cell: \_\_\_\_\_

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: \_\_\_\_\_ Is it a Middle School? \_\_\_\_ High School? \_\_\_\_

Expected grad. Date: \_\_\_\_\_ Graduating with Diploma or Certificate? \_\_\_\_\_

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

Name \_\_\_\_\_ Type of program: \_\_\_\_\_ Dates: \_\_\_\_\_

Address: \_\_\_\_\_

Name \_\_\_\_\_ Type of program: \_\_\_\_\_ Dates: \_\_\_\_\_

Address: \_\_\_\_\_

Is applicant able to read? \_\_\_\_ Yes \_\_\_\_ No. If yes, at what grade level? \_\_\_\_\_

Has applicant had any experience working in customer service, food service, or a retail environment? \_\_\_\_ No \_\_\_\_ Yes

Can applicant stand for 2 hours at a time? \_\_\_\_ 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

Takes direction \_\_\_\_\_

Sweeps floors \_\_\_\_\_

Ties apron independently \_\_\_\_\_

Mops floors \_\_\_\_\_

Asks for help \_\_\_\_\_

Puts on latex/vinyl gloves independently \_\_\_\_\_

Identifies food such as cupcakes, cookies or cakes \_\_\_\_\_

Uses an I-pad \_\_\_\_\_

Counts coins and bills \_\_\_\_\_

Wraps food with plastic wrap \_\_\_\_\_

Understands need to wash hands \_\_\_\_\_

Opens and closes containers \_\_\_\_\_

Makes coffee or tea \_\_\_\_\_

Refills containers \_\_\_\_\_

Empties trash bags into garbage cans \_\_\_\_\_

**TEEN'S DISABILITY/IES (PLEASE DESCRIBE.):**

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Mobility: Ambulatory \_\_\_\_\_ Yes \_\_\_\_\_ No

Personal Care: Independent \_\_\_\_\_ Yes \_\_\_\_\_ No

Communication: Verbally \_\_\_\_\_ Yes \_\_\_\_\_ No

If no, what means/methods are used to communicate?

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

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

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

Learning disability/ies

Limited vision/Blind

Behavioral Concerns

Limited mobility

Mild intellectual disability

Psychiatric diagnosis/mental illness\*

Attention deficit hyperactivity disorder

Autism spectrum disorder

Moderate intellectual disability

Chronic medical condition

Anxiety disorder

Depression

Speech/language impairment

OCD

Hearing loss

Needs 1:1 support

Cerebral palsy

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? \_\_\_\_\_

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**\*Psychiatric/Psychological/Emotional Disability**

Primary Diagnosis: \_\_\_\_\_

Additional Diagnoses: \_\_\_\_\_

**If you have had one, please attach a copy of the most recent psychological evaluation results.**

Please comment on any of the above with regard to educational settings. Please indicate any restrictions from participation in STEP activities. Use additional space, if necessary.

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**BEHAVIORAL CONCERNS**

Does applicant (check if yes):

<input type="checkbox"/> Threaten to do physical violence	<input type="checkbox"/> Damage public property
<input type="checkbox"/> Ignore or resist following instruction or routines	<input type="checkbox"/> Use angry language
<input type="checkbox"/> Damage personal property	<input type="checkbox"/> Have violent temper or outbursts
<input type="checkbox"/> Damage the property of others	<input type="checkbox"/> Have a record of any arrests
<input type="checkbox"/> Lie or steal	<input type="checkbox"/> Have socially unacceptable sexual habits
<input type="checkbox"/> Abuse self	<input type="checkbox"/> Exhibit offensive behavior, including bullying, with peers
<input type="checkbox"/> Have difficulty with authority figures	
<input type="checkbox"/> Abuse substances	

Please comment on any of above with regard to educational settings:

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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: \_\_\_\_\_ Date \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date \_\_\_\_\_

## **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.)**

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## **HEALTH AND MEDICAL INFORMATION**

Name of Primary Physician: \_\_\_\_\_

Telephone number: \_\_\_\_\_ FAX: \_\_\_\_\_

Name(s) of Psychiatrist/Neurologist (if applicable): \_\_\_\_\_

Telephone #(s): \_\_\_\_\_

### **Allergies:**

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Date of last Tetanus shot: \_\_\_\_\_ History of gluten intolerance or Celiac disease?  Yes  No

### **Medical concerns:**

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### **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 custodial parent/guardian: \_\_\_\_\_ Date: March 2026 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: March 2026 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: March 2026 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: March 2026 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. If there has been one, attached is also the most recent psychological evaluation report.

Signature of parent/guardian: \_\_\_\_\_ Signed Date: \_\_\_\_\_

### HOW DID YOU FIND OUT ABOUT SUNFLOWER BAKERY?

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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**