

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.):

Mobility: Ambulatory ____ Yes ____ No

Personal Care: Independent ____ Yes ____ No

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.

| | |
|---|--|
| <input type="checkbox"/> Learning disability/ies | <input type="checkbox"/> Limited vision/Blind |
| <input type="checkbox"/> Behavioral Concerns | <input type="checkbox"/> Limited mobility |
| <input type="checkbox"/> Mild intellectual disability | <input type="checkbox"/> Psychiatric diagnosis/mental illness* |
| <input type="checkbox"/> Attention deficit hyperactivity disorder | <input type="checkbox"/> Autism spectrum disorder |
| <input type="checkbox"/> Moderate intellectual disability | <input type="checkbox"/> Chronic medical condition |
| <input type="checkbox"/> Anxiety disorder | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Speech/language impairment | <input type="checkbox"/> OCD |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Needs 1:1 support |
| <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> 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: _____

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.

BEHAVIORAL CONCERNS

Does applicant (check if yes):

____ Threaten to do physical violence

____ Ignore or resist following instruction or routines

____ Damage personal property

____ Damage the property of others

____ Lie or steal

____ Abuse self

____ Have difficulty with authority figures

____ Abuse substances

____ Damage public property

____ Use angry language

____ Have violent temper or outbursts

____ Have a record of any arrests

____ Have socially unacceptable sexual habits

____ 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: _____ 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.)

HEALTH AND MEDICAL INFORMATION

Name of Primary Physician: _____

Telephone number: _____ FAX: _____

Name(s) of Psychiatrist/Neurologist (if applicable): _____

Telephone #(s): _____

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 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?

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