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

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

There will be 2 sessions offered between March and June 2026. The curriculum will be the same for both 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 and 2nd choices of sessions below.

The following sessions from March through June will meet from 4-6:30 each day:
_____Session 9 March 16-17, 23-24 _____Session 10 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:_____

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 cooking or baking at home? ____No ____Yes

Can applicant stand for 2-1/2 hours at a time 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 ____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.

____ Learning disability/ies
____ Behavioral Concerns
____ Mild intellectual disability
____ Attention deficit hyperactivity disorder
____ Moderate intellectual disability
____ Anxiety disorder
____ Speech/language impairment
____ Hearing loss
____ Cerebral palsy
____ Epilepsy/ seizure disorder Date of last seizure: _____Motor or Non- motor? _____
____ Limited vision/Blind
____ Limited mobility
____ Psychiatric diagnosis/mental illness*
____ Autism spectrum disorder
____ Chronic medical condition
____ Depression
____ OCD
____ Needs 1:1 support
____ 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: _____

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