

**Sunflower Bakery Application**  
**Sunflower Teen Baking Exploration Program (STEP) 2026-27**

Please provide all information requested below. All students must be **at least 15 years old**.

**July and August** classes will meet on **Mondays through Thursdays** from **4-6:30 PM**. Students will be **accepted on a first-come, first-served basis for each session**. A student may register for only one Baking class during the summer.

**School-year classes** will meet on **Mondays and Tuesdays** from **4-6:30pm** for **2 consecutive weeks**. A student may register for up to one Baking session and one Hospitality session during the school year.

**TEEN BAKING SESSION CHOICE**

Please select your 1st and 2nd choices of sessions from previous Instructions page.

**July or August:** First choice: \_\_\_\_\_ Second choice: \_\_\_\_\_

**School year:** First choice: \_\_\_\_\_ Second choice: \_\_\_\_\_

**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 ___         | Uses whisk ___  |
| Measures with measuring cups ___   | Uses spatula ___  |
| Understands need to wash hands ___ | Uses food processor ___   |
| Turns oven off/on ___              | Ties apron independently ___  |
| Uses electric hand mixer ___       | Uses microwave ___  |
| Uses electric stand mixer ___      | Washes dishes ___   |
| Removes pans from oven ___         | Uses digital kitchen scale ___  |
| Identifies utensils ___            | Consistently identifies and differentiates sizes of measuring cups and spoons ___ |
| Measures with measuring spoons ___ |   |

**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.**

- |   |  |
|---|--|
| <input type="checkbox"/> Learning disability/ies                  | <input type="checkbox"/> Autism spectrum disorder  |
| <input type="checkbox"/> Behavioral Concerns                      | <input type="checkbox"/> Chronic medical condition |
| <input type="checkbox"/> Mild intellectual disability             | <input type="checkbox"/> Depression                |
| <input type="checkbox"/> Attention deficit hyperactivity disorder | <input type="checkbox"/> OCD                       |
| <input type="checkbox"/> Moderate intellectual disability         | <input type="checkbox"/> Needs 1:1 support         |
| <input type="checkbox"/> Anxiety disorder                         | <input type="checkbox"/> Other: _____              |
| <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*    |  |

\_\_\_ 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.

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**BEHAVIORAL CONCERNS**

Does applicant (check if yes):

\_\_\_ Threaten to do physical violence

\_\_\_ Damage public property

\_\_\_ Ignore or resist following instruction or routines

\_\_\_ Use angry language

\_\_\_ Damage personal property

\_\_\_ Have violent temper or outbursts

\_\_\_ Damage the property of others

\_\_\_ Have a record of any arrests

\_\_\_ Lie or steal

\_\_\_ Have socially unacceptable sexual habits

\_\_\_ Abuse self

\_\_\_ Exhibit offensive behavior, including bullying, with peers

\_\_\_ Have difficulty with authority figures

\_\_\_ 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.)**

\_\_\_\_\_  
\_\_\_\_\_

**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: July 2026 through June 2027

**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: July 2026 through June 2027

**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: July 2026 through June 2027

**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: July 2026 through June 2027

**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**