2017 Lettuce Grow Project

April 1 - September 30 2017
at the
Marshall University Student Gardens,
Huntington, WV

Project Application Packet

*The Lettuce Grow Project is sponsored by the Center for Supported Employment and in collaboration with the Sustainibility Department at Marshall University, and The Autism Training Center.

Dear Parents/Guardians,

January 26, 2017

We are very excited to be able to introduce the joys gardening to members of the developmentally disabled community here in Huntington. The goals of the Lettuce Grow Project are; to teach concepts of nature, gardening and the weather; to help students be a participant in their own lives; and to create positive social connections within the broader Huntington community.

We are accepting applications for project members aged 14 years or older with a current primary medical or educational diagnosis of a developmental disability and/or an autism spectrum disorder (e.g., PDD-NOS, Autism, and Asperger's) or developmental delay. Because of the nature of the project, and the volunteer and collaborative efforts of the wider community working on the project, we are unable to provide 1:1 supervision of project members. **In order to participate in the pilot project, members must be accompanied by a responsible adult (can be waiver staff) during all project activities.** Due to the individualized programming that will be provided, a limited number of applications will be accepted.

This project will be held on the Marshall University campus and run from March 1st - August 1st 2017. The project schedule will vary for participants based on the types of activities they have chosen to do. There will be set day/times for project members to attend "Garden Learning" meetings in addition to daily/weekly garden tasks for project members in either the Marshall Greenhouse or Student Gardens on campus. This project is very hands-on and integrates a variety of methods and Horticultural Therapy techniques to help our project members benefit from their time in the gardens. A detailed schedule for your student's participation in the garden project will be provided once the project starts. Garden Learning times can be during the day or in the evening as the growing season changes.

Parents/Guardians will need to provide transportation to and from the project locations (either Marshall Greenhouse or the Marshall Student Garden). Parking is available around the campus at paid meters or you can by a day parking pass from the Marshall Parking Office. **Thanks to a generous donation from a sponsor, the application fee of 25$ has been waived for the pilot project members**. Parents/Guardian will need to purchase the Project Book/tool kit that their project member will use during the project. (This includes the Jr. Master Gardener workbook ($15) as well as other garden tools.)More information will be provided, but cost is expected to be around $50. We are looking for a sponsor for the pilot project Tool-Kits, (if you are interested in sponsoring or working on fundraising for this please contact us).

The project is designed to improve the social and vocational skills of young adults with autism spectrum disorders and developmental delays by providing innovative programming and therapeutic gardening activities. Project participants will participate in various small and large group gardening activities involving embedded academics (such as language skills through blogging and social interactions with typical peers and other project members), math tasks, science tasks integrated with outdoor skills, and working together to prepare harvested crops for sale at the Wild Ramp in Huntington. Project members will also receive programming where the focus will be to enhance socials skills. These social skills, as well as all behavior intervention plans, will be supported by staff throughout the project with therapeutic gardening activities. For example, project members will work alongside Marshall University students and faculty members in the gardens, learning how to plant, grow, harvest and finally market the bounty from their efforts. This requires teamwork, social interaction, flexibility and dedication.

Finally, the project will provide individualized project plans focused on his/her vocational skills goals. The goal of the project is to increase job readiness skills in an entrepreneurial setting, where team members will learn horticulture, science, and business skills within an integrated community setting.

Enclosed you will find the 2017 Lettuce Grow initial application and information regarding the project. The application is an important document that will be utilized in providing the best experience possible for the participant. We encourage families to include as many of the "experts" in their particpants's life as possible when completing the application packet. These "experts" may include parents, caregivers/staff, teachers, behavior consultants, psychologists, psychiatrists, physicians and counselors.

To ensure a successful project experience, participants are expected to attend their assigned garden tasks and learning activities. Project participants are expected remain in the program for the entire growing season. Please provide written notice in advance if the participant will not be able to complete an assigned project task because of vacation or illness so those tasks can be reassigned to other team members. A garden is a living thing, and as a project member we expect you to take responsibility for your assigned tasks. Continued absence will be grounds for dismissal from the project.

The initial project application is due by Monday, February 20th. As you are completing the application, please feel free to contact us with questions. We can be reached by email at sloftus@csemploy.org. Please do not fax your project application. However they can be submitted electronically using the aforementioned email address.

Send applications to:

ATTN: **Lettuce Grow Project**

Sara Loftus
Center For Supported
Employment
1650 8th Avenue
Huntington, WV 25703

Sincerely,

Sara Loftus, MCP
Executive Director, Center for Supported Employment

Identifying Information

Participant's Name (First, Middle, Last): _____

Preferred Name: _____ Age: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone Number: (____)_____ Gender: ____ Male ___ Female

Height: _____ Weight: _____

Previous gardening experience? Where: _____ When: _____

Guardian/Parent Contact Information

Parent/Guardian Name: _____ Home Phone: (_____)_____
Address: _____ City:_____ State: _____ Zip: _____
Place of Employment: _____ Work Phone: (_____)_____
Cell Phone: (_____)_____ email address:_____

Please provide information about the Responsible Adult that will accompany the project participant during all Project Activities:

Staff Person/Responsible Adult Name: _____
Address: _____
Place of Employment: _____
Home Phone: (___)_____ State: _____ Zip: _____
Work Phone: (_____)_____
Cell Phone: (_____)_____ email address:_____

Emergency Contact Information

These are the person(s) who will be contacted to accept responsibility if the parent/guardian cannot be reached to during the project activities.

1. Name: _____ City: _____
   Phone: _____ Cell Phone: _____
Relationship to participant: _____

2. Name: _____ City: _____
   Phone: _____ Cell Phone: _____
Relationship to participant: _____

Insurance coverage for accidents or illnesses while participating in programs at Marshall University is the primary responsibility of the participant and/or his/her family. **Please attach a copy of insurance/Medicare/Medicaid cards.**

Primary Insurance
Is the applicant covered by hospitalization insurance? Yes No
Name of Insurance: _____
Policy, Identification, or Group Number: _____
Insurance is in whose name? _____
Name of employer if insurance is through work: _____
Medicare Number: _____ Medicaid Number: _____

Secondary Insurance
Is the applicant covered by hospitalization insurance? Yes No
Name of Insurance: _____
Policy, Identification, or Group Number: _____
Insurance is in whose name? _____
Name of employer if insurance is through work: _____
Medicare Number: _____ Medicaid Number: _____

General Consent and Waiver

I, as the parent and/or legal guardian of _____ (the "Applicant"), give consent for the Applicant to attend the 2017 Lettuce Grow project and to participate in all project activities except those specified in this application. Project activities may include but are not limited to walking field trips on Marshall University campus, Outdoor Pursuits in the gardens throughout the campus, work with garden tools, including but not limited to shovels, garden scissors, clippers or other sharp objects and work within the Campus Greenhouse. I represent and warrant to the 2017 Lettuce Grow project that the applicant is physically and mentally able to participate in all project activities except those that I have specified **or will be accompanied at all times by a Responsible Adult who will supervise the participant.**

I understand and acknowledge that the Marshall University Sustainability Department and the Center for Supported Employment reserves the right to refuse any person and agree that the applicant will be attending voluntarily and without monetary compensation. I acknowledge and agree that I have been provided the opportunity to see and inspect the project facilities at Marshall University. On behalf of the applicant and myself we agree to assume all risk of injury and loss arising out of the condition of the project, the applicant's participation in project activities and the activities of other project members or volunteers participating in such activities. Also, on behalf of the applicant and myself we agree to assume all risk of injury and loss arising out of any of behavioral and academic/vocational interventions and any other interventions implemented during project. In consideration of and return for the services, facilities, and other assistance provided to the applicant by Marshall University, the applicant and I release Marshall University (and its Board of Trustees, officers, employees, agents, and volunteers),the Center for Supported Employment (and its Board of Directors, officers, employees, agents, and volunteers), the Autism Training Center and any other University or Community Volunteer from any and all liability, claims and actions that may arise from injury or harm to us, from our death or from damage to our property in connection with participation in project at the Center for Supported Employment and Marshall University. In consideration of and return for the services, facilities, and other assistance provided to the applicant by the Center for Supported Employment and Marshall University, the applicant and I release the Center for Supported Employment (and its Board of Directors, officers, employees and agents) and Marshall University (and its Board of Directors, officers, employees and agents) from any and all liability, claims and actions that may arise from injury or harm to us, from our death or from damage to our property in connection with participation in the 2017 Lettuce Grow project. I understand that this Release covers liability, claims, and actions caused entirely or in part by any acts or failures to act of Center for Supported Employment (and its Board of Directors, officers, employees and agents) and Marshall University (or its Board of Directors, officers, employees, or agents) including but not limited to negligence, mistake, or failure to supervise by Center for Supported Employment (and its Board of Directors, officers, employees and agents) and Marshall University.

I understand that the participant is expected to attend project during their agreed upon shifts and training times. Project members are expected to attend the duration of the project. If project members expect to be absent due to vacation or illness, I understand that I need to notify Project staff with advance written notice so gardening tasks can be reassigned during their absence. We recognize that this Consent and Waiver means I am giving up, among other things, rights to sue the Center for Supported Employment's Directors, Officers, staff and volunteers, as well as Marshall University's Board of Directors, officers, employees, or agents for injuries, damages, or losses we may incur. I also understand that this Consent and Waiver binds our respective heirs, executors, administrators, and assigns, as well as ourselves.

I have read this entire Consent and Waiver; I fully understand it and I, on behalf of myself and the participant and our respective heirs, executors, administrators, and assigns, agree to be legally bound by it. I have read and understand the 2017 Lettuce Grow Project Admission Policy of The Center for Supported Employment, I fully understand it and agree to be bound by it. This is release of your rights. Read it carefully before signing. I understand that completion of this form does not guarantee acceptance to the 2017 Lettuce Grow project. I verify that all information contained in this application is true and accurate to the best of my knowledge and belief.

_____ _____ _____

Signature of parent/guardian Printed name of parent/guardian Date

FORM A

INFORMATION AND AUTHORIZATION FOR MEDICAL CARE

Child's Name: _____

As a parent or guardian I understand that the information requested on this form is intended to help inform program staff of any pre-existing medical conditions the participant may have. If the participant has a pre-existing medical condition, participation in any strenuous activities or recreational time may not be recommended. The Center for Supported Employment and/or Marshall University requests the information below so that, in case of emergency, we will have accurate information so that we can provide and/or seek appropriate treatment for the participant. You are accountable for providing an accurate medical history. **Final determination about whether the participant should participate is the responsibility of you and your physician.** If the participant has any medical issue that is not requested below, but which you think is important, please include that information. It is recommended that you consult with a physician prior to participation in this Program. If you are uncertain about any preexisting medical conditions, it is your responsibility to consult with your own physician prior to participation in this Program. Please answer all of the questions. If you answer yes to any of the following questions, please explain as indicated. Use back and/or additional paper if needed.

I understand that the Center for Supported Employment and/or Marshall University does not provide any health insurance for the participant while participating in the Program.

PART 1. MEDICAL INFORMATION

Physician's Name _____ Phone Number _____

Date of most recent tetanus toxoid immunization _____

Do you have health/accident insurance? (circle one): YES NO

If yes, please indicate policy number, name and address of insurance company.

Policy #_____ Company Name/Address_____
_____

PLEASE ENCLOSE A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD WITH THIS FORM

For the following, circle appropriate response and explain as appropriate:

Does the participant have any limiting medical conditions that you or your doctor feel would limit project participation? YES NO

If yes, identify and explain:

Is the participant currently taking medication that may interfere with ability to safely participate in Program? YES NO

If yes, please indicate the medication and the condition being treated:

Does the participant have a history of allergies or reactions to medications, insect stings, or plants?

YES NO

If yes, please explain:

Does the participant have a history of food allergies? YES NO

If yes, please explain:

Does the participant have a history of, or is currently suffering from a medical condition which we need to be aware of? YES NO

If yes, please explain:

PART 2: AUTHORIZATION FOR MEDICAL CARE

By my signature below I grant the Center for Supported Employment and/or Marshall University permission to seek medical care for the participant in the event of illness or medical emergency and to release the medical information as needed on this form in pursuit of that medical care. I will assume the financial responsibility for such medical care.

As a parent, or guardian I understand and acknowledge that my failure to disclose relevant information may result in harm to the participant and/or others during this Program. By signing my name I represent and warrant that I have provided all materials and important information to the Center for Supported Employment and/or Marshall University pertaining to the participant medical, mental and physical condition and that it is accurate and complete. I agree to notify the Center for Supported Employment and/or Marshall University of any changes in the participant mental, physical or medical condition prior to the participant participation in the scheduled Program. By revealing or disclosing the above medical information I acknowledge that it will not be used by the Center for Supported Employment and/or Marshall University personnel or employees to determine the participant ability to participate safely in activities. I understand that, if the participant chooses to participate in activities, he/she does so voluntarily and of his/her own accord and the final decision regarding participation is solely the responsibility of myself and the participant.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____

FORM B

AUTHORIZATION FOR SELF-ADMINISTRATION OF REQUIRED MEDICATION

Participant's Name:

_____

This form must be completed fully in order for the participant to self-administer required medication. A new medication administration form must be completed for each Program attended by the participant, for each medication, and each time there is a change in dosage or time of administration of a medication. **Self-medication requires licensed health care authorization and signature on this form as well as the parent/ guardian signature.**

All prescription medications, including medications for conditions such as food, drug or insect allergies; diabetes; asthma; or epilepsy may be brought to the Program under the condition that the participant can self-manage care and delivery of medication with written authorization to do so by a licensed health care provider. Prescription medication must be in its original container labeled by the pharmacist or prescriber. Label must include the name, address and phone number for pharmacist or prescriber. Containers must hold only the amount required for the time the participant will be attending the Program.

PRESCRIBER AUTHORIZATION FOR SELF-ADMINISTRATION OF PRESCRIPTION MEDICATION

Medication Name: Dose:

Condition for which medication is being administered:

Specific Directions (e.g., on empty stomach/with water, etc.):

Time/frequency of administration:

If PRN, frequency:

If PRN, for what symptoms:

Relevant side effects:

Medication shall be administered from (date) _____to _____

Special Storage Requirements:

Is the participant capable of self-managed care? YES NO

Prescriber's Name/Title:

Prescriber's Place of Employment:

Telephone: Fax:

I hereby affirm that the participant has been instructed in the proper self-administration of the prescribed medication(s).

Prescriber's Signature:

Date:

I authorize and recommend self-administration by the participant for the above medication. I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician. I shall indemnify and hold harmless the Center for Supported Employment (its Board of Trustees, Administration, Faculty, Staff, Students, Volunteers, and all other officers, directors, employees and agents), Marshall University, (its Board of Trustees, Administration, Faculty, Staff, Students, Volunteers, and all other officers, directors, employees and agents) against any claims that may arise relating to the participant self-administration of prescribed medication.

I have legal authority to consent to medical treatment for the participant named above, including the self-administration of medication at the above referenced Program.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____

FORM C

CONSENT FOR OVER-THE-COUNTER MEDICATIONS

Participant's Name: _____

Over-the-Counter (OTC) Medication may at times need to be administered, if approval is indicated by the participant's parent or guardian. Please complete the following section to save time if the participant needs any of these OTC medications during his/her program participation.

Note: Unless we have parental/guardian authorization, we cannot administer ANY medications.

I hereby authorize that the following medications may be given to the participant if the need arises. You may dispense only those checked.

_____Ointments for minor wound care, first aid as directed. (Antiseptic, anti-itch, anti-sting, antibiotic, sunburn)
_____Topical Benadryl for swelling, hives, allergic reaction, as directed.
_____Medicated lip ointment for dry, chapped lips, lip blisters or canker sores as directed.
_____Hydrocortisone ointment as directed for mild skin irritations, poison ivy, and insect bites.

_____Medicated powder for skin irritation as directed.

_____Calamine lotion for bug bites and poison ivy.

_____Sunscreen.

_____Bug repellent.

_____Other (list any other approved over-the-counter drugs).

Program staff reserves the right to use generic equivalents when available for the name brand over-the-counter medications listed above.

I understand that such administration will not be done under the supervision of medical personnel. I also agree that any first aid treatment may be given as needed.

Parent/guardian will be contacted if any conditions develop requiring treatment with any of the above over-the-counter medications that are not checked.

I understand that these over-the-counter medications are not necessarily kept on hand and available to be administered immediately.

I authorize the administration of over-the-counter medications to the participant as indicated above. I shall indemnify and hold harmless the Center for Supported Employment Program Staff, its Board of Directors, Volunteers, Marshall University, its Board of Trustees, Administration, Faculty, Staff, Students, Volunteers, and all other officers, directors, employees and agents against any claims that may arise relating to the participant being administered the above indicated over-the-counter medications.

I have legal authority to consent to medical treatment for the participant named above, including the administration of the medications listed above at the above referenced program.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____

FORM D

MEDIA, PHOTO, AND VIDEO, AND LIABILITY RELEASE

PLEASE READ THIS DOCUMENT CAREFULLY BEFORE SIGNING. THIS IS A LEGALLY BINDING DOCUMENT.

Participant's Name:

_____

In consideration for the participant participation in the program, I, the undersigned parent/guardian of the participant named above, hereby grant to the Center for Supported Employment (its Board of Trustees, Administration, Faculty, Staff, Students, and all other officers, directors, employees and agents ("CSE") and Marshall University, its Board of Trustees, Administration, Faculty, Staff, Students, and all other officers, directors, employees and agents ("University") the right to reproduce, use, exhibit, display, broadcast, distribute, exploit, modify, adapt, and create derivative works of surveys, data collection, questionaires, photographs, videotaped images or video/audio recordings of my participant ("Materials") by incorporating them into publications, catalogues, brochures, books, magazines, photo exhibits, motion picture films, videos, electronic media, web sites, and/or other media, or commercial, informational, educational, advertising, or promotional materials or publications related thereto ("Works"). It is agreed that the Works will be used in connection with CSE and/or University business, the activities of the CSE and/or University, or for research, promoting, publicizing or explaining CSE and/or University activities or events.

Materials may appear in any of the wide variety of formats and media now available to CSE and/or the University and that may be available in the future, including but not limited to print, broadcast, videotape, CD-ROM and electronic/online media.

I waive my right to inspect or approve any Works that may be created by CSE and/or the University using the Materials and waive any claim with respect to the eventual use to which Materials may be applied.

I understand and agree that CSE and/or the University is and shall be the exclusive owner of all right, title, and interest, including copyright, in the Works, and any commercial, informational, educational, advertising, or promotional materials containing the Materials. All electronic or non-electronic negatives, positives, and prints are owned by CSE and/or the University. I also understand that neither I nor my participant will receive compensation in connection with the use of the participant image.

I, on behalf of my participant, furthermore release, indemnify and hold harmless the Center for Supported Employment and Marshall University from and against any and all liability, actions, debts, claims and demands of every kind whatsoever, specifically including, but not limited to, any claim for negligence or negligent acts or omissions and any present or future claim, loss or liability for injury to person or property that my participant may suffer, for which my participant may be liable to any other person, or that may or does arise out of the use of the Materials.

This RELEASE contains the entire agreement between the parties and the terms of this RELEASE are contractual and not a mere recital. The information I have provided is disclosed accurately and truthfully. I have been given ample time to read this document and I understand and agree to all of its terms and conditions. I acknowledge that I am signing this document freely and voluntarily. My signature on this document is intended to bind not only myself but also my successors, heirs, representatives, administrators, and assigns.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

FORM E

DISCIPLINARY PROCEDURES

Participant's Name: _____

Disciplinary Procedures:

Each program participant has a reasonable expectation to enjoy a positive program experience. Therefore, the misbehavior of one participant, or a group of participants, should not be permitted to impact negatively on the program experience of others. Most programs are short in duration, so prompt action is required when problems occur. Parents and participants should be aware of the disciplinary policy.

First Offense: Participants failing to adhere to program rules, or exhibiting behavior clearly intended to annoy or endanger other participants, will be formally warned by a Program Counselor and informed that subsequent misbehavior will result in formal counseling by the Program Director and/ or Program Volunteer.

Second Offense: Subsequent misconduct will result in counseling by the Program Director and/or Associate Director and a warning that further misconduct will result in removal from Program. At this point, the Program Director and/or Associate Director will contact the parent or guardian to advise him/her of the situation and the possible need for picking the the participant up from project if there is further misconduct.

Third Offense: Any further inappropriate behavior will result in expulsion from Program.

NOTE: THE CENTER FOR SUPPORTED EMPLOYMENT EXPECTS EACH PARTICIPANT TO HAVE A SUCCESSFUL PROGRAM EXPERIENCE. ANY OF THE STEPS OUTLINED ABOVE MAY BE OMITTED OR REPEATED AT THE DISCRETION OF PROGRAM STAFF. PARTICIPANTS DISMISSED FROM PROGRAM FOR DISCIPLINARY REASONS WILL NOT RECEIVE A REFUND OF ANY FEES PAID TO ATTEND PROGRAM.

It should be understood this procedure is intended to provide a reasonable and consistent method for dealing with the type of behavior that can be disruptive to a program, but is not so egregious as to warrant immediate dismissal from the program. It in no way precludes immediate dismissal from the program for more serious disciplinary problems or violations of campus or program regulations.

A serious disciplinary problem is defined as one in which the program staff determines that a participant is engaging in inappropriate behavior that includes, but is not limited to the following: actions which put the participant, other participants, or program staff member's safety in jeopardy; physical, emotional, or electronic harassment/harm against self, program staff or fellow program participants; inflicting physical or emotional harm on self or others, vandalism or destruction of CSE/University property; theft of CSE/University property or the property of another participant; consistently disrupting the program; possession of alcohol, drugs, or weapons; fighting; sexual harassment; or behavior that is serious enough to warrant a third offense.

By my signature below I understand the disciplinary procedures described above. I understand failure of participant named above to demonstrate proper conduct during project may result in early dismissal from the program without any refund of fees paid to attend. I pledge to have the participant abide by all program rules and to exercise appropriate behavior and proper respect for others.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ **Date:** _____

Participant Information

To assist the 2017 Lettuce Grow project staff in developing individualized programming for the participant we must utilize all information available to us. Please complete the following information to the best of your ability. Including any additional information regarding participant's specific needs is highly encouraged. The 2017 Lettuce Grow project staff will make every effort to be educated regarding particpant's specific needs given the information provided via the application and check-in process. Project staff will receive training regarding basic Behavior Management techniques as well as Aggression Management. Because a primary focus of the project is to modify behaviors that interfere with learning and developing appropriate social skills the staff will include professionals trained in the area of applied behavioral analysis. Therefore, behavior plans will be developed and implemented as needed. The project Directors will communicate with participants, families and caregivers regarding the scope of limitation of accommodating campers' specific needs as necessary.

Particpant's Name: _____

Current Grade and school (if still attending): _____
Diagnosis: _____

Degree of Developmental Disability/ASD/PDD (self identification: how does your DD/ASD/PDD affect your daily life?):

1 2 3 4 5 6 7 8 9 10
Not Much Mildly Impacts Me Severely Impacts me Very Severely

Does the participant have a one-on-one aide /staff at school or when going into the community? If no, what is the classroom ratio of teachers and aides to students?

☐ Yes
☐ No, ratio _____

Does the applicant have any specific behaviors that may be of concern in adjusting to the project? ☐ yes ☐ no If yes, please describe below.

_____
_
_____

Are there any precipitating factors for specific behaviors?

_____
_____

What methods are most effective in diminishing challenging behaviors?

_____
_____
_____

What are activities or items that are enjoyable and/or can be used as reinforcement?

_____
_____
_____

What type of interests and hobbies does the applicant have?

_____
_____
_____

Does the participant have a highly focal or specific interest (e.g., Legos, computers, dinosaurs, princesses, fishing, etc.) that often interferes with learning? Yes ____ No _____
If yes, please describe the highly focal or specific interest.

_____
_____
_____

Does the applicant have any likes or dislikes that may be useful or for which the staff should be aware?

_____
_____
_____

Does the applicant have any self-stimulatory behaviors? Mark: N=Never, C=Current, P=Past

____Genital Stimulation ____Oral Stimulation (biting, chewing, mouthing objects)
____Hand Flapping ____ Rocking
____Head Banging ____Self-Abusive
____Other (please describe) _____

If the applicant engages in self-stimulatory behaviors, how are the behaviors handled at home and/or school/community?

_____
_____
_____

Has the applicant ever displayed any of the following behaviors? Mark: N=Never, C=Current, P=Past

____Wandering	____Stealing	____Lying
____Bullying	____Impulsivity	____Sexual Acting Out
____Withdrawal	____Swearing	____Anxiety/Depression
____Noncompliance	____Mood Swings	____Verbal Threats
____Hitting	____Throwing Objects	____Scratching
____Pinching	____Biting	____Spitting
____Hair Pulling	____Kicking	____Disrobing
____Suicidal Ideation/Attempts		____ Darting/Running Away

Has the applicant ever shown any physical aggression? ☐yes ☐no
If yes, check all that apply:

- ☐Toward Self
- ☐Toward Peers
- ☐Toward Adults
- ☐Toward Animals

Strategies that are successful in managing challenging behaviors? (check all that apply)

- ☐Sensory Input
- ☐Time Outs
- ☐Redirection
- ☐Removal From Group
- ☐Positive Reinforcement
- ☐"Safe" Place
- ☐One-on-One Attention
- ☐Constant Supervision

Comments:
_____
_____
_____

Daily Living Skills:

Toileting
_____ Independent ____ Some Assistance ____ Total Assistance
Comments:
_____
_____
_____

Eating:
_____ Independent ____ Some Assistance ____ Total Assistance
Comments:
_____
_____
_____

How does the applicant communicate?
☐ Verbal ☐ Gestures ☐ Sign Language
☐ PECS-Picture Exchange Communication System ☐ Communication Device
☐ Other _____
Comments:
_____
_____
_____

Does the applicant use any adaptive equipment (i.e., wheelchair, communication device, pressure vest, weighted vest, weighted blanket, etc…)?
_____
_____
_____

Sensory Issues: (please check all that apply)
☐ Tactile—sensitivity to touch/textures, defensiveness to touch/textures
☐ Auditory—sensitivity to sounds/noises
☐ Visual—sensitivity to lights, colors, etc.
How are sensory issues handled?
_____
_____
_____

Are there any recent traumatic events that may affect the project experience? ☐ yes ☐ no
Comments:
_____
_____
_____

Is there any other important information that would be useful or for which the project staff should be aware?
_____
_____
_____

Programming Restrictions:
Please note that all project activities will be facilitated by trained program staff. Staff will be assisting participants as needed for the highest level of inclusion possible for each specific participant.

Are there any project activities that the applicant should not engage in?
Please Check All That Apply

☐ Walking Long Distances

☐ Walking Short Distances

☐ Using sharp tools/cutting tools

☐ Activities that may include physical contact (e.g.,hand over hand)

☐ Helping build garden boxes, moving garden equipment

☐Interaction with animals (e.g., therapy dog, chickens, Alpacas)

☐Greenhouse (where temperatures can be high)

☐ Other _____

☐Other _____

☐

☐

Project Cost and Transportation

Thanks to a generous donation, participation in the Pilot Lettuce Grow Project project is free to all participants who are accepted to participate. Parents/Staff are expected to provide transportation for the participant. There will be a Project Learning Kit that participants will need to purchase in order to participate in the program. Costs for the learning kit will be emailed closer to project start date, but we expect it to be around $50. We are actively seeking sponsorship for the Project Learning Kits.

Meals

Parents will need to provide a sack lunch or snack each day if participants need/want it.

Cancellations

To ensure a successful learning experience, project members are expected to participate during their assigned project tasks and learning activities. Participants are expected to remain in the project for the entire growing season. Participants who miss more than 5 days during project without advanced written notice will not be allowed to continue to participate in the project . **Please let us know of any vacations you have planned so that we can reassigned any project tasks to other participants while you are gone.**

_____

Signature of Parent/Guardian or Other Responsible for Payment

_____

Printed Name

_____

Date