



Unpaid Internship Application

Return to: Lettuce Dream, PO Box 272, Maryville, MO 64468-Phone-660-224-2203

Acceptance Criteria: You must be a person with intellectual or developmental disabilities in the age range of 18-35 years of age, live in Nodaway, Atchison, Holt, Andrew, Gentry or Worth county (Missouri), and have graduated high school. Do you meet this criteria? **YES** **NO**

Intern Name: _____

Address: _____ City: _____ State: _____

E-Mail: _____

Home Phone: _____ Cell Phone: _____

High School Graduates: Please describe your post high school education, training, or employment if any:

References: Please list 3 references from your school, training, or employment experiences. An example might be someone from school, your church, work, or volunteer experience that can tell us about you/your child. List reference name, address, and phone number on the lines below.

1. Name: _____ Address: _____

Phone Number: _____ Connection to Applicant: _____

2. Name: _____ Address: _____

Phone Number: _____ Connection to Applicant: _____

3. Name: _____ Address: _____

Phone Number: _____ Connection to Applicant: _____

Have you applied for services through Department of Mental Health (DMH) or Vocational Rehabilitation? **YES** **NO** Date: _____

Eligible for services? **YES** **NO** Date: _____

Waiver Slot Assigned? **YES** **NO** Date: _____

Medicaid Number: _____

Service Coordinator's Name/Email: _____

Referring Agency: _____

Intern Background Information:

1) Please describe any health concerns or restrictions related to the Intern's ability to participate in the Lettuce Dream Greenhouse: _____

2) Does the Intern have any behavior issues? **YES** **NO** (Ex: aggressive behavior, tantrums, wandering, etc...) Explain the answer:

3) What known triggers are there for the behavior issues listed above?

Behavior Management: (Circle Yes or No)

YES	NO Shy	YES	NO Attempts to run away
YES	NO Sometimes destructive	YES	NO Responds to correction well
YES	NO Works alone	YES	NO Hyperactive
YES	NO Threatens others	YES	NO Outgoing
YES	NO Adapts to new situations well	YES	NO Works in groups
YES	NO Hits or hurts self/others		

Background checks are required to work, train, or volunteer at Lettuce Dream. Have you completed a background check with the Family Care Safety Registry before? **YES** **NO**

A \$13.00 fee will be charged to each Intern to pay for the background check. Please complete the form below and have it notarized or bring it into Lettuce Dream to be notarized, with your payment of \$13.

Signature of person completing form: _____
Relationship to Intern: _____ Date: _____

Lettuce Dream’s Release Form for an Intern: I represent and warrant that to the best of my knowledge and belief I am/my child is physically and mentally able to participate in the Lettuce Dream program. I understand that Interns will follow all of the rules of the Lettuce Dream program and will stay within the defined premises of these programs. I understand that the relationship between Lettuce Dream and the Intern is an “at will” arrangement that may be terminated at any time without cause by either the Intern or Lettuce Dream. If a medical emergency should arise during my/my child’s participation in the Lettuce Dream program at a time when I am not personally able/present to be consulted regarding my/my child’s care, I authorize Lettuce Dream to take whatever measures are necessary to protect my/my child’s health and wellbeing, including, if necessary, hospitalization. Lettuce Dream has my permission (both during and any time after) to use my/my child’s likeness, name, voice, or words in either television, radio, film, newspapers, magazines and other media in any form for the purposes of advertising or communicating the purposes and activities of Lettuce Dream and /or applying for funds to support these purposes and activities. I waive and release all claims against Lettuce Dream, its board of directors, employees, volunteers or program participants for any and all injuries and/or losses sustained by myself, my heirs and assigns while participating in the Lettuce Dream program. I, the undersigned, have read and fully understand the provision of the above release, and if I am a Intern someone has explained these provisions to me. By signing this release form I agree to the above provisions. If I am the parent/guardian of the Intern named on this form I am agreeing to the above provisions on my own behalf and on behalf of the Intern named on this application. If I am a witness to an adult Intern I certify that I have reviewed this release with the Intern and am satisfied that the Intern understands this release and has agreed to its terms.

Signature of Intern: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

Signature of Witness for Adult Intern: _____ Date: _____

An equal opportunity/access/affirmative action/pro-disabled and veteran employer

Declaration of Consent: Please indicate your consent to each item by signing below each statement.

1. Emergency Medical Treatment Consent: I, _____, or parent/guardian of _____, give permission to the medical personnel selected by Lettuce Dream to order hospitalization, treatment, anesthesia, and surgery if necessary in case of an emergency when parents cannot be reached. I have supplied Lettuce Dream with a sealed envelope that contains a list of all my/my child's medications and dosages. In the event of any changes I will supply an updated list. I understand this will be provided to medical professionals in the event of an emergency.

Signature: _____ Date: _____

2. Photograph Release Consent: I, _____, or parent/guardian of _____, give Lettuce Dream permission to use my/or my child's name, picture, and/or video in presentations, training purposes, media releases, newsletters and marketing materials solely for the purpose of promoting Lettuce Dream and its program.

Signature: _____ Date: _____

3. Waiver of Liability Consent: I, _____, or parent/guardian of _____, agree to release Lettuce Dream and all staff and volunteers from all liability for any additional illness or injury to my child and for any accidental damage or destruction of my child's property during their participation in the Lettuce Dream program.

Signature: _____ Date: _____

4. Greenhouse Consent: I, _____, or parent/guardian of _____, understand that Lettuce Dream is a training program. Interns will not be paid during their time in training at the Lettuce Dream greenhouses. If a paying position should become available at a later date after all training has been completed a new application process will take place.

Signature: _____ Date: _____

Intern Plan of Care

Today's Date: _____ Name of the Lettuce Dream Participant:

First _____ Middle _____ Last _____

Medical Diagnosis: _____

Height _____ Weight _____ Blood type _____ M _____ F _____

Home Address: _____ City: _____ State: _____ Zip: _____

Emergency contact name: _____ Emergency phone: _____

Family Information: Father's Full Name: _____

E-mail address: _____

Employer: _____

Work Phone: _____ Cell Phone: _____

Mother's Full Name: _____

E-mail address: _____

Employer: _____

Work Phone: _____ Cell Phone: _____

If Intern lives with a caregiver, please list primary caregiver information, as well Caregiver's Full Name:

E-mail address: _____

Employer: _____

Work Phone: _____ Cell Phone: _____

Contacts/Assistance in the Community: Please list primary physician name, address and phone number:

Physician Name: _____

Address: _____ Phone: _____

Medical Information: Health Insurance Co. _____

ID # _____ Group # _____ Hospital Preference _____

If you have a medical plan of care for emergencies, please attach a copy for us. The same plan that you had for school or other medical needs is acceptable

Allergies to foods or environmental allergies (i.e. bee stings) Allergy Severity of Reaction Action

Steps 1. _____

2. _____

3. _____

Please list any medical or special precautions for managing the following concerns. Is there any other condition we need to be made aware of? Please list and explain.

Seizures:

Other:

Communication Needs: Can communicate with others using: Please check all that apply. _____ Words
____ Phrases ____ Sentences ____ Babbles ____ Gestures ____ Sign Language _____ I-Pad ____ No devices
needed _____ Other

Can understand what others say: Please check one. ____ All the time ____ Most of the time ____ Some of
the time ____ Recognizes only family voices

Able to read: _____ Yes _____ No Able to read a clock: _____ Yes _____ No Dietary Needs/Eating Habits:

Meals are not provided. Info. for emergency purposes only. Special

diet: _____

Foods to avoid/Allergies to foods or medications: _____

Toilet/Hygiene Needs: Any toileting or hygiene problems? _____ Yes _____ No

Please make a list of things the Intern likes to do. (We use this list to help volunteers experience success when communicating with the program participants)

1. _____
2. _____
3. _____
4. _____
5. _____

Greenhouse Essentials

Please initial on the line if the Intern can complete these essentials:

- _____ Be able to work in the mornings
- _____ Has reliable transportation to and from the greenhouse
- _____ Will drink water as needed due to the greenhouse's warm/hot conditions
- _____ Can tolerate heat/ cold

Send completed form to: Lettuce Dream, PO Box 272, Maryville, MO 64468.

If you have further questions call: 660-224-2203 or email: support@lettucedream.org