43rd Anniversary Deaf Youth Sports Festival
"Making Deaf Olympians!"
July 13-19, 2025
ALL PARTICIPANTS MUST BE DEAF OR HARD OF HEARING

MDO – PART

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PLEASE PRINT CLEARLY

Participant Name ____

Address _______________________ City ________________ST ____ Zip Code ______

BIRTHDATE ___/___/___ Male __ Female __ Height ____ Weight ____ Shoe size (bowling) ______

<u>T-SHIRT SIZE</u> CHILD: S ___ M ___ L ___ ADULT: S ___ M ___ L ___ XL ___ XXL ___

How many years has Participant attended MDO? This is first time _____ # Years _____

Parent/Guardian Name ______________________ Relationship to Participant _____________

Parent Email __________________ Phone/VP _______________ Cell/Text _____________

<u>EMERGENCY CONTACT Other than parents</u> (**MUST** be able to reach IF we cannot reach parents.)

Name ___________________ Relationship to participant __________ Phone/Text __________
(grandparent, aunt/uncle, friend, etc)

<u>COMMUNICATION PREFERENCE</u> (check as many as apply)

ASL ___ Signed English ___ Total Communication ___ Oral ___ Other ______________________

<u>SCHOOL INFORMATION</u> (For Opening Ceremony-Please enclose/attach recent photo of Participant)

School name (as of May 2025) ______________________ City/State of School _____________

Grade _____ Mascot ___________ School Colors ______________ HS Graduation Year _____

<u>ARRIVAL / DEPARTURE INFORMATION</u>

Participants wanting to drive or ride with driving Participants MUST submit permission form before arriving.
Participants do not become responsibility of MDO until **AFTER** registration.
Participants may not leave until **AFTER** Closing Ceremony.

I'M GOING TO MDO! I will arrive on July _____, 2025 at _____ AM / PM.

By CAR – Driver name ____________________ Other riders __________________________
By PLANE – Airline name _______________Flight # __________ Tkt # _________________
By TRAIN / BUS – Station _______________ Train / Bus # ______ Tkt # _________________

I'M GOING HOME! I will leave on July 19, 2025 at _____ AM / PM.

By CAR – Driver name ____________________ Other riders __________________________
By PLANE – Airline name _______________Flight # __________ Tkt # _________________
By TRAIN / BUS – Station _______________ Train / Bus # ______ Tkt # _________________

Go to www.mdoyouth.org for information about MDO Emergency Contacts, Fees, Fundraising and Scholarships, Registration, Opening and Closing Ceremonies, Dress Code, What to Bring and NOT bring, and more.

Email: teammdo@gmail.com Website: www.mdoyouth.org
The Deaf Youth Sports Festival, Inc., P. O. Box 421304, Indianapolis, IN 46242

PARTICIPANT CODE OF CONDUCT   **Participant Name** ___________________________________

As an MDO Participant, I will

- Be Respectful, Cooperative, and contribute positively to the MDO experience
- Practice excellent Sportsmanship, strong Teamwork, and outstanding Character
- Listen and follow all directions from my Coach and all other MDO Staff
- Keep my hands to myself, NO hitting, fighting, or bullying
- Have fun, but not at the expense of others
- Have a good attitude and use appropriate language (NO obscenity)
- Respect MDO property and Iowa Deaf School property
- NOT bring ANY electronic devices (cell phone, IPad, computers, game devices, spinners, etc) to MDO
- NOT engage in sexual activity
- NOT use, possess, distribute, sell, or be under the influence of alcohol, drugs, or cigarettes
- NOT possess weapons of ANY kind
- NOT participate in acts of vandalism of any kind

IF I violate the MDO Code of Conduct, I will accept the consequences, which MAY include

- Losing competition time
- Losing event and entertainment time
- Losing medals and record standing
- Being disqualified for Mr and Miss Olympian competition (High School Participants)
- Time Out
- Writing letters of apology
- Paying for damages
- Having my parents called
- Being sent home (at parents expense)
- NOT being allowed to return to MDO (for serious offenses)
- Prosecution if situation warrants (unlawful activity out of MDO hands)

Participant Signature ________________________   **Parent Signature** ___________________________

AUTHORIZATIONS – READ CAREFULLY

1. The Deaf Youth Sports Festival/MDO MUST have advance knowledge of special needs for your child. This information will be treated confidentially and used to make preparations. We will not use this information as a basis for rejecting this application. I understand that if MDO is unable to appropriately provide for my child BECAUSE I HAVE NOT PROVIDED THE NECESSARY INFORMATION, my son/daughter may be sent home AT MY EXPENSE.
*****Parent/Guardian Initials** ______

2. I give permission for Over the Counter medications (such as Tylenol, Benadryl, etc) to be administered to my child if needed. I have informed MDO of any and ALL allergies and reactions. *****Parent/Guardian Initials** ______

3. I agree that MDO and Iowa School for the Deaf and all its facilities are to be released from liability in connection with medical treatment and unavoidable accidents. *****Parent/Guardian Initials** ______

4. The Deaf Youth Sports Festival has my permission to use emergency medical measures in the event of an emergency. *****Parent/Guardian Initials** ______

5. I give permission for my child to leave the grounds and its facilities with authorized staff for outings and trips. *****Parent/Guardian Initials** ______

6. I agree that The Deaf Youth Sports Festival has my permission to use pictures, names, and other art forms depicting myself and/or my child in MDO publications and promotions. *****Parent/Guardian Initials**______

Parent Signature ____ **Date** ____________________________

Completion Checklist

_____ Completed all Medical/Health information   _____ Check enclosed for $ ___________

_____ Included all Contact Information   _____ Paid $_____ online (PayPal) _____ (date)

_____ Explained Code of Conduct to my child   _____ Payments $_____ on _____ (start date)

_____ Initialed all Authorizations ***   _____ Contact me about payments/scholarships

_____ Signed where requested   _____ Contact me about fundraising/volunteering

MDO – PART

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HEALTH / SPECIAL NEEDS INFORMATION

Participant Name ____

To expedite registration and ensure medications are administered correctly, please complete all information below and list all medications to be given at MDO on the **Participant Medical Information Check-In Form.** Thank you for your patience and understanding to help us make MDO a fun and safe experience for all.

HEALTH INSURANCE INFORMATION – Please include a copy of child's Health Insurance Card

Physician's Name ______________________________ Physician's Phone Number ______________________

Physician's Address ____________________________ City _________________ST ____ Zip ____________

Health Insurance Company __________________________ Policy # _________________________________

SPECIAL NEEDS – Please be specific. If more space is needed please attach a separate page.

Tubes in ears ___ YES ___ NO Hearing Aids ___ YES ___ No Cochlear Implant ___ YES ___ NO

Special diet/ food restrictions ___ YES ___ NO If YES, please explain _________________________________

Physical / Sports limitations ___ YES ___ NO If YES, please explain _________________________________

Heart procedures / surgeries ___ YES ___ NO If YES, please explain _________________________________

Other conditions ___ YES ___ NO If YES, please explain _________________________________

Social, emotional, behavioral___ YES ___ NO If YES, please describe the need and type of support needed

(Behavior modification with tokens, timeout, etc.) ____

Other information ___ YES ___ NO If YES, please explain (overly shy, aggressive, short temper, bed

wetter, etc) ____

All medications will be administered based on the prescription label instructions unless a doctor statement is provided authorizing something different. It is the Parent/Guardian's responsibility to provide written doctor's authorization of changes or they will be administered based on the prescription label instructions.

I affirm that the medication, health, and special needs information listed above is accurate. I understand and agree with the above statement.

Parent / Guardian Signature ___________________________________ Date ____________________________

TO BE COMPLETED AT REGISTRATION

I have reviewed the medical and health information
Given to MDO and verify that it is correct.
Parent / Guardian Initials: ______ Date ______

TO BE COMPLETED AT CHECK-OUT

I have received all of my child's belongings and
Medications.
Parent / Guardian Initials: ______ Date _____

Email: teammdo@gmail.com **Website:** www.mdoyouth.org

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PLEASE PRINT CLEARLY
PARTICIPANT MEDICAL INFORMATION CHECK-IN

Participant Name _____________________________________ **Birthdate** ___/___/___

Parent/Emergency Contact Name ______________________________ **Phone #** _________________________

Date of last tetanus shot ____________ **Immunizations / shots up to date?** ___ **YES** ___ **NO**

Allergies? ___ **YES** ___ **NO If YES be specific! (Food, medicine, insects, plants, etc)** _________________________

Taking medication at MDO? ___ **YES** ___ **NO If YES, list below. (Split pills if necessary, before bringing.)**

Name of Medication _________________________
Strength (mg, mcg, etc) _______________________
Amount (1 tablet, 1 tsp, etc.) ___________________
Prescribing Dr's name ________________________
Receives medication (check all that apply)
Breakfast _____ Special Instructions:
Lunch _____
Dinner _____
Bedtime _____
Other _____

Name of Medication _________________________
Strength (mg, mcg, etc) _______________________
Amount (1 tablet, 1 tsp, etc.) ___________________
Prescribing Dr's name ________________________
Receives medication (check all that apply)
Breakfast _____ Special Instructions:
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