



**44th Anniversary Deaf Youth Sports Festival**  
**“Together Everyone Achieves More!”**  
**July 12-18, 2026**

**MDO – PART**

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

**ALL PARTICIPANTS MUST BE DEAF OR HARD OF HEARING**

**PLEASE PRINT CLEARLY**

Participant Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip Code \_\_\_\_\_

BIRTHDATE \_\_\_/\_\_\_/\_\_\_ Male \_\_\_ Female \_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Shoe size (bowling) \_\_\_\_\_

T-SHIRT SIZE 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 \_\_\_\_\_

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

Name \_\_\_\_\_ Relationship to participant \_\_\_\_\_ Phone/Text \_\_\_\_\_  
 (grandparent, aunt/uncle, friend, etc)

**COMMUNICATION PREFERENCE (check as many as apply)**

ASL \_\_\_ Signed English \_\_\_ Total Communication \_\_\_ Oral \_\_\_ Other \_\_\_\_\_

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

School name (as of May 2026) \_\_\_\_\_ City/State of School \_\_\_\_\_

Grade \_\_\_\_\_ Mascot \_\_\_\_\_ School Colors \_\_\_\_\_ HS Graduation Year \_\_\_\_\_

**ARRIVAL / DEPARTURE INFORMATION**

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 \_\_\_\_\_, 2026 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 18, 2026 at \_\_\_\_\_ AM / PM.

By CAR – Driver name \_\_\_\_\_ Other riders \_\_\_\_\_

By PLANE – Airline name \_\_\_\_\_ Flight # \_\_\_\_\_ Tkt # \_\_\_\_\_

By TRAIN / BUS – Station \_\_\_\_\_ Train / Bus # \_\_\_\_\_ Tkt # \_\_\_\_\_

Email: [teammdo@gmail.com](mailto:teammdo@gmail.com) Website: [www.mdoyouth.org](http://www.mdoyouth.org)

The Deaf Youth Sports Festival, Inc., P. O. Box 421304, Indianapolis, IN 46242

**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 ***         | _____ Signed where requested                     |

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PLEASE PRINT CLEARLY

**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 \_\_\_\_\_

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**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 \_\_\_\_\_

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 Strength (mg, mcg, etc) \_\_\_\_\_  
 Amount (1 tablet, 1 tsp, etc.) \_\_\_\_\_  
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**If more space is needed, use separate sheet.**

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