MISSOURI COMMISSION FOR THE DEAF AND HARD OF HEARING

3216 Emerald Lane, Suite B
Jefferson City, MO 65109
(573) 526-5205 (Voice/TTY)
MCDHH@mcdhh.mo.gov
http://www.mcdhh.mo.gov

Becky Davis
Executive Director

Michael L. Parson
Governor

To be eligible for the Missouri Deaf Youth Leadership, a student must:

- Be between the ages of 11-18
- Enrolled in middle -high school, or plan to graduate in December 2024- May 2025
- Demonstrated leadership potential and involvement in their school and community.
- Lived in Missouri
- Deaf, Hard of hearing, or Deafblind

What to bring for Missouri Deaf Youth Leadership?

- ☐ Sleeping bag, blanket, and Pillow
- ☐ Pajamas, slipper, and robe
- ☐ Toothbrush, Toothpaste, deodorant, hairbrush, and other personal hygiene
- ☐ Medication, if necessary

Instruction to complete application:

- ☐ Please read all instructions and fill out the entire application. *Incomplete application will not be accepted.*
- ☐ Answers may be dictated to a parent, guardian, or scribe; however, the content must be the work of the student.

Before Submitting, please verify:

- ☐ Application is completed.
- ☐ Must answer the essay questions in a written paragraph.
- ☐ Reference letter from one adult outside the school.
- ☐ Must be submitted by email or mail.
- ☐ All paperwork must be submitted by email or mail at the same time.

Options for submit completed application:

Complete and share and send as a PDF to: Sonya.Smith@mcdhh.gov

or

Print, Complete and Mail to:
Missouri Commission for the Deaf and Hard of Hearing
3612 Emerald Lane Suite B, Jefferson City, MO 65109

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Have questions or need assistance submitting your application?

Call at (573) 298-6778 or mail to: sonya.smith@mcdhh.mo.gov

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Missouri Deaf Youth Leadership Application

Student Information:

First Name ____________ Middle Name ____________ Last Name ____________

Preferred name ____________ Gender ____________ Pronouns ____________

Home Address ________________________________

Mailing Address ________________________________

City ____________ State ____________ Zip Code ____________

Cell phone ____________ Videophone ____________ Email ____________

Birth Date:
____/______/_____

Race:
- ☐ American Indian or Alaska native
- ☐ Asian
- ☐ Black/African American
- ☐ Hispanic or Latino
- ☐ White
- ☐ Other: ________________

Shirt Size (youth size):
- ☐ Small
- ☐ Medium
- ☐ Large
- ☐ X-Large

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Emergency Contact Information:

____
Parent/Guardian Name

____
Parent or Guardian Email

____
Parent or Guardian phone number

____
Relationship to the Student

Please Check the ones that apply:

How did you learn about Missouri Deaf Youth Camp:

- ☐ School
- ☐ Friend
- ☐ Internet/social media/email
- ☐ Transition event
- ☐ Other: ______________________________

Do you have vocational rehabilitation or rehabilitation services blind (RSB) counselor?

- ☐ Yes
- ☐ No
- ☐ I don’t know

Are you DMH Regional Office client?

- ☐ Yes
- ☐ No
- ☐ I don’t know

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☐

Have you participated at your local center for independent living (IL)?

- ☐ Yes
- ☐ No
- ☐ I don't know

Request Reasonable Accommodation:

Deaf/Hard of Hearing:

- ☐ Interpreting Services.
  Type: _______________
- ☐ Assistive listening devices.
- ☐ Note taker.

Deafblind:

- ☐ Braille.
- ☐ Large Print materials.
  Size:__________
- ☐ Assistance with mobility.
- ☐ Electronic format.
- ☐ SSP Services.

Mobility Disability:

- ☐ Power wheelchair/scooter.
- ☐ Manual wheelchair/scooter.
- ☐ Cannot walk stairs.
- ☐ Walker, cane, or crutches.
- ☐ Cannot walk long distances.

- ☐ Crohn's Disease
- ☐ Rheumatoid Arthritis
- ☐ Sickle Cells Anemia
- ☐ Autism
- ☐ Traumatic Brain Injury
- ☐ Down Syndrome
- ☐ Intellectual Disability
- ☐ Mental Health Disability
- ☐ Neuro/muscular disability (e.g., anxiety, depression, bipolar/mood disorder, obsessive-compulsive disorder, other)
- ☐ Learning Disability (e.g., dyslexia, dyscalculia, ADD/ADHA, other)
- ☐ Multiple Disability
- ☐ Chronic Illness (e.g. cancer, cystic fibrosis, diabetes, heart disease, other)
- ☐ Chemical/environmental sensitivity
- ☐ Other: _______________

Immune Disability:

Do you need personal care assistance?

Additional Accommodations:

____

____

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Food Allergy & Special Dietary Need:

____

____

Medication Authorization

Medial requirement:

Prescription medication shall be in the original container and labeled with the child's name, instructions, including times and amounts for dosages, and any physician's name. All non-prescription medications shall be in the original container and labeled by the parent(s) with the child's name and instruction for administration, including times and amounts for dosages. A separate form is needed for each medication. This form is valid only for the dates indicate below:

I authorized childcare personal to administer the following medication to my child:

____

(Proper name of the medications)

Child's full name: ___________________________ Date Medication taken from: ____________

Until: _____________ Dosage: ____________ Time(s) of the day: ______________

Possible side Effects: ______________________

Signature of the parent(s) or Guardian: ____________________ Date: ________________

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Work Experience (Paid or non-Paid)

Do you currently work?

- ☐ Yes
- ☐ No

If yes, where do you work?

____

What career field would you like to learn about?

____

School Information

Name of the school: ____________________ Current grade: ____________________

School phone number: __________________ Expected to graduate: _______________

Short Answer Questions: Read the questions below and answer in 2 or 3 sentences each.

1. Tell me why you choose to be a part of MODYL?

____
____
____
____

2. Why is leadership important?

____
____
____
____

3. List your three goals you have for your future?

____
____
____
____

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4. List three leadership strengths that you possess.

____
____
____
____
____

Reference:
Reference must be from outside the school. The other references may be any adult who knows you well, other than a parent or relative (for example, scout leader, employer, coach, community leader, etc.)

____________	____________	____________
Name	Position/Title	Phone number

____________	____________
Email	Relationship

Photo/Video Release Form

I hereby grant permission to use photograph an/or video of taken on April 26-27, 2024, at Missouri Commission for the Deaf and Hard of Hearing (MCDHH) hosted 2024 Missouri Deaf Youth Leadership (MDYL) located at Missouri School for the Deaf, Fulton, MO in publications, newsletter, online, and in other communications related to the mission.

____
Signature of adult, or guardian of children under age 18

Name______________________________

Address______________________________

Phone Number__________________________

Email address__________________________