

# Athletic Pre-Season Packet

## **OHSAA Physical Form:**

Physical forms must be completed and turned into the office or scanned into [westholmes.oh.finalforms.com](http://westholmes.oh.finalforms.com) before the first day of practice. Pomerene Kinetics is offering free physicals for all WH athletes. Date and flyer will be sent out to all athletes. Please call 330-674-4488 to make an appt.

**All forms must be completed on [westholmes\\_oh.finalforms.com](http://westholmes_oh.finalforms.com) before the first day of practice.**

## **Pay to Participate**

Payment must be turned into the High School (\$75)/Middle School (\$50) office by the scheduled due date. If payment is not received by the deadline, the athlete will not be able to participate in practices or games until payment is made. Cash or check only made payable to West Holmes High School or Middle School.

**Fall Pay to Play Due: August 27**

**Winter Pay to Play Due: December 3**

**Spring Pay to Play Due: March 23**

## **2026-27 Ticket Prices**

Varsity	Adult-\$8	Students-\$5
JV/Freshman	Adult-\$6	Students-\$4
Middle School	Adult \$6	Students-\$4

All passes can be purchased in the high school office starting July 1<sup>st</sup>.

## **Student Pass**

Passes are available for \$60.00 per student. The pass is good for any home middle school or high school events for the 2026-27 school year.

## **Adult Pass**

We will be offering a 20 punch pass for the 2026-27 school year. The pass is \$100.00 and can be used for multiple people & events. This is a cost savings of \$80.

## **Reserved Seat Pass**

Reserved seats are available for Football, Girls Basketball and Boys Basketball. Contact the high school office if you are interested in purchasing a reserved seat at 330-674-6085.

## **Family Pass**

We will be offering a Family Pass (family of four) for \$300.00. Any additional student pass is \$40. The passes are good for any home middle school or high school events for the 2026-27 school year.



**PREPARTICIPATION PHYSICAL EVALUATION | OHIO HIGH SCHOOL ATHLETIC ASSOCIATION | 2026-27**

**HISTORY FORM**

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Date of examination: \_\_\_\_\_ Sport(s): \_\_\_\_\_

Sex assigned at birth (F, M, or intersex): \_\_\_\_\_ How do you identify your gender? (F, M, non-binary, or another gender): \_\_\_\_\_

List past and current medical conditions. \_\_\_\_\_

\_\_\_\_\_

Have you ever had surgery? If yes, list all past surgical procedures. \_\_\_\_\_

\_\_\_\_\_

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

\_\_\_\_\_

\_\_\_\_\_

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

\_\_\_\_\_

\_\_\_\_\_

Patient Health Questionnaire Version 4 (PHQ-4)  
*Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)*

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS		
(Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)		
	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU		
	Yes	No
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU			
(CONTINUED)			
	Yes	No	
9. Do you get light-headed or feel shorter of breath than your friends during exercise?			
10. Have you ever had a seizure?			
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY			
	Unsure	Yes	No
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?			
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTs), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?			
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?			



# ATHLETES WITH DISABILITIES FORM: SUPPLEMENT TO THE ATHLETE HISTORY

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

1. Type of disability:		
2. Date of disability:		
3. Classification (if available):		
4. Cause of disability (birth, disease, injury, or other):		
5. List the sports you are playing:		
	Yes	No
6. Do you regularly use a brace, an assistive device, or a prosthetic device for daily activities?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed as having a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "Yes" answers here:

\_\_\_\_\_  
\_\_\_\_\_

Please indicate whether you have ever had any of the following conditions:

	Yes	No
Atlantoaxial instability		
Radiographic (x-ray) evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "Yes" answers here:

\_\_\_\_\_  
\_\_\_\_\_

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: \_\_\_\_\_

Signature of parent or guardian: \_\_\_\_\_

Date: \_\_\_\_\_



# MEDICAL ELIGIBILITY FORM

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Year of Graduation: \_\_\_\_\_

Medically eligible for all sports without restriction

Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

\_\_\_\_\_  
\_\_\_\_\_

Medically eligible for certain sports

\_\_\_\_\_  
\_\_\_\_\_

Not medically eligible pending further evaluation

Not medically eligible for any sports

Recommendations: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): \_\_\_\_\_ Date of Exam: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of health care professional: \_\_\_\_\_, MD, DO, DC, NP, or PA

## SHARED EMERGENCY INFORMATION

Allergies: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Medications: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Other information: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Emergency contacts: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_