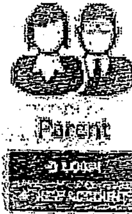
FINALFORMS™

PARENT REGISTRATION

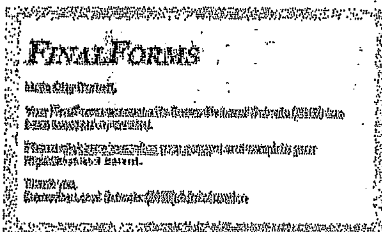
HOW DO I SIGN UP?



1. Go to https://northwestcinci-oh.finalforms.com
2. Click **NEW ACCOUNT** under the Parent Icon

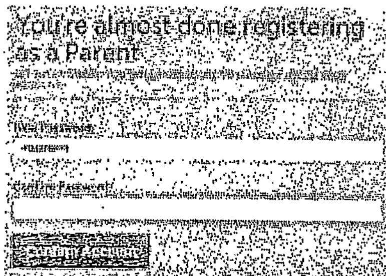
3. Type your NAME, DATE OF BIRTH and EMAIL, then click **REGISTER**

4. Check your Email for a FinalForms Email, and click **CONFIRM YOUR ACCOUNT** in the email text.

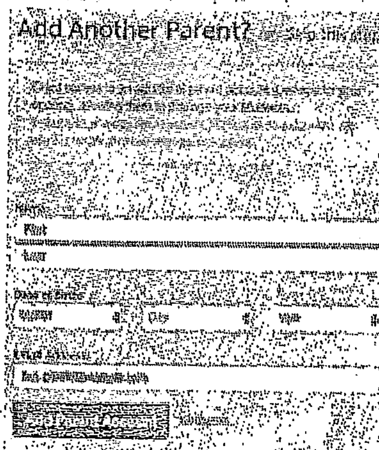


NOTE: You will receive an email within 2 minutes prompting you to confirm and complete your registration. If you do not receive an email, check your spam folder. If you still do not see the FinalForms email, please email support@finalforms.com

5. Create your new FinalForms password and click **CONFIRM ACCOUNT**



6. You may be asked if you want to grant another Parent/Guardian access to your registered students. Either click **SKIP THIS STEP** or type the NAME, DATE OF BIRTH and EMAIL, then click **ADD PARENT ACCOUNT.**



7. Your account(s) will be created, you can then click **REGISTER STUDENT** for your first child.

FINALFORMS

REGISTERING A STUDENT

WHAT INFO WILL I NEED?

- Basic Medical History & Health Info
- Insurance Company & Policy Number
- Doctor, Dentist & Hospital Information
- Email Address for BOTH you and your student (if required by your district)

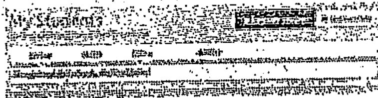
HOW DO I REGISTER MY FIRST STUDENT?

****IMPORTANT**** *If you have followed the steps on the previous page, you may Jump to Step 3.*

1. Go to https://northwestcincl-oh.finalforms.com

2. Click **LOGIN** under the Parent Icon

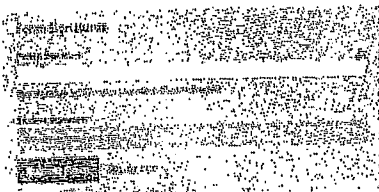
3. Click **REGISTER STUDENT**



4. Complete the form including the Student's Legal Name, ***EMAIL ADDRESS***, Date of Birth, Gender, Graduation Year, Home Address and any other information required by your School District, then click **CREATE STUDENT**
NOTE: *A student email address may or may not be required depending on your school district preferences. If so, the email address provided may be used to send reminders to your student.*

5. ***If your student plans to participate in a sport, activity, or club*** please click the checkbox for each. Click **UPDATE** after making your selection.
NOTE: *A selection can be changed any time until the registration deadline.*

6. Complete each form and sign your full name (e.g. "John Smith") into the Parent Signature field at the bottom of the page. After signing, click **SUBMIT FORM** and move on to the next form.



7. When all forms are complete, you will see a "Forms Finished" message.

****IMPORTANT**** ***If required, an email will automatically be sent to the email address that you provided for your student prompting him/her to sign Student forms requiring his/her signature.***

8. Click **MY STUDENTS** if you are done, or **REGISTER ANOTHER STUDENT** if you need to add another.
9. At any point in the future, you may login at any time and click the **UPDATE FORMS** button

PREPARTICIPATION PHYSICAL EVALUATION | Ohio High School Athletic Association – 2021-2022

HISTORY FORM

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

Name: ______________________ Date of birth: __________ Grade in School: __________

Date of examination: ______________ Sport(s): ______________________

Sex assigned at birth (F, M, or intersex): __________ How do you identify your gender? (F, M, or other): __________

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 (i.e., 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	**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?		

COVID-19 QUESTIONS ABOUT YOU	Yes	No
14. Have you had COVID-19 or tested positive for COVID-19?		
15. If answered yes, when did you have/test positive for COVID-19?		
16. If answered yes, have you had any ongoing medical issues secondary to COVID-19?		
17. If answered yes, were you cleared by a health care provider following the diagnosis to return to sport activity?		
18. Has a physician ever denied or restricted your participation in sports for reasons related to COVID-19?		
19. If answered yes, please state reasoning:		
20. Have you been vaccinated for COVID-19?		
21. Please list date(s) of vaccine(s), if applicable:		

BONE & JOINT QUESTIONS	Yes	No
22. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
23. Do you have a bone, muscle, ligament, or joint injury that bothers you?		

MEDICAL QUESTIONS	Yes	No
24. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
25. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
26. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
27. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		
28. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
29. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
30. Have you ever become ill while exercising in the heat?		
31. Do you or does someone in your family have sickle cell trait or disease?		
32. Have you ever had, or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (CONTINUED)	Yes	No
33. Do you worry about your weight?		
34. Are you trying to or has anyone recommended that you gain or lose weight?		
35. Are you on a special diet or do you avoid certain types of foods or food groups?		
36. Have you ever had an eating disorder?		

FEMALES ONLY	Yes	No
37. Have you ever had a menstrual period?		
38. How old were you when you had your first menstrual period?		
39. When was your most recent menstrual period?		
40. How many periods have you had in the past 12 months?		

Explain "Yes" answers here:

____

____

____

____

____

____

____

____

____

____

____

____

...continued next page...

Additional questions, as authorized by the Ohio High School Athletic Association, were not a part of the revised 5th edition PPE as authored by the American Academy of Pediatrics and are optional.

1. On average, how many days per week do you engage in moderate to strenuous exercise (makes you breathe heavily or sweat)? ________________
2. On average, how many minutes per week do you engage in exercise at this level? ________________

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: ______________________________

© 2019 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgment.

PREPARTICIPATION PHYSICAL EVALUATION | Ohio High School Athletic Association – 2021-2022

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: ____________________

© 2019 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgment.

PREPARTICIPATION PHYSICAL EVALUATION – Ohio High School Athletic Association – 2021-2022

PHYSICAL EXAMINATION FORM

Name: ______________________ Date of Birth: ____________ Grade in School: ________

PHYSICIAN REMINDERS

1. Consider additional questions on more-sensitive issues.
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height: Weight:		
BP: / (/) Pulse: Vision: R 20/ L 20/ Corrected: ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

[a] Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): ______________________ Date: __________

Address: ______________________ Phone: __________

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

© 2019 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgment.

PREPARTICIPATION PHYSICAL EVALUATION | OHIO HIGH SCHOOL ATHLETIC ASSOCIATION – 2021-2022

MEDICAL ELIGIBILITY FORM

Name: ______________________________ Date of Birth: ______________ Grade in School: ________

☐ 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: ____

____

____

© 2019 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgment.