

NOTE: The preparticipation physical examination must be conducted by a health care provider who 1) is a licensed physician, advanced practitioner, nurse, or physician assistant; and 2) completed the Student-Athlete Cardiac Assessment Professional Development Module.

PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM

Name Ceren Alkanat Date of birth 5-14-2005

PHYSICIAN REMINDERS

- 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, 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 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?
- Consider reviewing questions on cardiovascular symptoms (questions 5-14).

Date of Exam: 9-5-17

EXAMINATION		
Height <u>63.8</u>	Weight <u>144.8</u>	☐ Male ☒ Female
BP <u>111/65</u>	Pulse <u>75</u>	Vision R 20/ <u>30</u> L 20/ <u>30</u> Corrected ☒ Y ☐ N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance Marten stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)	☒	
Eyes/nose/throat - Pupils equal - Hearing	☒	
Lymph nodes	☒	
Heart* - Murmurs (auscultation standing, supine, +/- Valsalva) - Location of point of maximal impulse (PMI)	☒	
Pulses Simultaneous femoral and radial pulses	☒	
Lungs	☒	
Abdomen	☒	
Genitourinary (males only)*	☒	
Skin HSV lesions suggestive of MRSA, urea corporis	☒	
Neurologic*	☒	
MUSCULOSKELETAL	☒	
Neck	☒	
Back	☒	
Shoulder/arm	☒	
Elbow/forearm	☒	
Wrist/hand/fingers	☒	
Hip/thigh	☒	
Knee	☒	
Leg/ankle	☒	
Foot/toes	☒	
Functional Duck-walk, single leg hop	☒	

*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

*Consider GI exam if in private setting. Having third party present is recommended.

*Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☒ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

☐ Not cleared

☐ Pending further evaluation

☐ For any sports

☐ For certain sports _____

Reason _____

Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam 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, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) (print/type) Carol Stewart, CAP Date 9-5-17
 Address Auburn Montgomery SHS Phone 204-244-3281
 Signature of physician, APN, PA [Signature]

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New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

8-2001/0410

**■ PREPARTICIPATION PHYSICAL EVALUATION
CLEARANCE FORM**

Name Ceren Alkanat Sex ☐ M ☒ F Age 12 Date of birth 5-14-2005

☒ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

☐ Not cleared

☐ Pending further evaluation

☐ For any sports

☐ For certain sports _____

Reason _____

Recommendations _____

EMERGENCY INFORMATION

Allergies none

Other Information _____

HCP OFFICE STAMP

SCHOOL PHYSICIAN:

Reviewed on _____ (Date)
Approved _____ Not Approved _____
Signature: _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam 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 clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) _____ Date _____

Address _____ Phone _____

Signature of physician, APN, PA _____

Completed Cardiac Assessment Professional Development Module

Date _____ Signature _____

State of New Jersey
DEPARTMENT OF EDUCATION

HEALTH HISTORY UPDATE QUESTIONNAIRE

Name of School Haddonfield Middle School

To participate on a school-sponsored interscholastic or intramural athletic team or squad, each student whose physical examination was completed more than 90 days prior to the first day of official practice shall provide a health history update questionnaire completed and signed by the student's parent or guardian.

Student Ceren Alkanat Age 12 Grade _____

Date of Last Physical Examination May 14-2016 Sport _____

Since the last pre-participation physical examination, has your son/daughter:

1. Been medically advised not to participate in a sport? Yes ☐ No ☒

If yes, describe in detail _____

2. Sustained a concussion, been unconscious or lost memory from a blow to the head? Yes ☐ No ☒

If yes, explain in detail _____

3. Broken a bone or sprained/strained/dislocated any muscle or joints? Yes ☐ No ☒

If yes, describe in detail _____

4. Fainted or "blacked out?" Yes ☐ No ☒

If yes, was this during or immediately after exercise? _____

5. Experienced chest pains, shortness of breath or "racing heart?" Yes ☐ No ☒

If yes, explain _____

6. Has there been a recent history of fatigue and unusual tiredness? Yes ☐ No ☒

7. Been hospitalized or had to go to the emergency room? Yes ☐ No ☒

If yes, explain in detail _____

8. Since the last physical examination, has there been a sudden death in the family or has any member of the family under age 50 had a heart attack or "heart trouble?" Yes ☐ No ☒

9. Started or stopped taking any over-the-counter or prescribed medications? Yes ☐ No ☒

If yes, name of medication(s) _____

Date: 9-1-2017 Signature of parent/guardian [Signature]

PLEASE RETURN COMPLETED FORM TO THE SCHOOL NURSE'S OFFICE

E14-00284

HADDONFIELD PUBLIC SCHOOLS ATHLETIC EMERGENCY INFORMATION

Student's Name: Ceren Alkanat Birth Date: 5-14-2005

Parent/Guardian: Gokhan Alkanat Phone #: H#
W#
334-6690371 other# cell

Address: 279 Lake Street, Haddonfield, N.J.

Allergies to food and/or drugs: none

Known medical problems: none //

List Medications: none

If you are uninsured, can someone contact you about family care? YES ☒ NO ☐

Health insurance: will have it after November 18, 2017 ID #: _____

Emergency contacts, other than parent/guardian. MUST HAVE TRANSPORTATION.

1. Jim Newell Home# Work# 1-856-256-4012

2. _____ Home# _____ Work# _____

Date: 9-1-2017 Parent/Guardian Signature: [Signature]

Sport: _____ Grade: _____

Office Use Only

Medical Quest Y ☐ N ☐ GPA Credits

Physical Date _____ Eligible? Y ☒ N ☐

ATTENTION PARENT/GUARDIAN: The preparticipation physical examination (page 3) must be completed by a health care provider who has completed the Student-Athlete Cardiac Assessment Professional Development Module.

PREPARTICIPATION PHYSICAL EVALUATION HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep a copy of this form in the chart.)

Date of Exam

Name Ceren Aikana Date of birth 5-14-2005
Sex F Age 12 Grade _____ School Haddonfield Middle Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

none

Do you have any allergies? ☐ Yes ☒ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No	MEDICAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☒	26. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☒
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections ☐ Other: _____	☐	☒	27. Have you ever used an inhaler or taken asthma medicine?	☐	☒
3. Have you ever spent the night in the hospital?	☐	☒	28. Is there anyone in your family who has asthma?	☐	☒
4. Have you ever had surgery?	☐	☒	29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?	☐	☒
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No	30. Do you have groin pain or a painful bulge or hernia in the groin area?	☐	☒
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?	☐	☒	31. Have you had infectious mononucleosis (mono) within the last month?	☐	☒
6. Have you ever had discomfort, pain, lightheadedness, or pressure in your chest during exercise?	☐	☒	32. Do you have any rashes, pressure sores, or other skin problems?	☐	☒
7. Does your heart ever race or skip beats (irregular beats) during exercise?	☐	☒	33. Have you had a herpes or MRSA skin infection?	☐	☒
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease ☐ Other: _____	☐	☒	34. Have you ever had a head injury or concussion?	☐	☒
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)	☐	☒	35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?	☐	☒
10. Do you get lightheaded or feel more short of breath than expected during exercise?	☐	☒	36. Do you have a history of seizure disorder?	☐	☒
11. Have you ever had an unexplained seizure?	☐	☒	37. Do you have headaches with exercise?	☐	☒
12. Do you get more tired or short of breath more quickly than your friends during exercise?	☐	☒	38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☒
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	39. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☒
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?	☐	☒	40. Have you ever become ill while exercising in the heat?	☐	☒
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?	☐	☒	41. Do you get frequent muscle cramps when exercising?	☐	☒
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?	☐	☒	42. Do you or someone in your family have sickle cell trait or disease?	☐	☒
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?	☐	☒	43. Have you had any problems with your eyes or vision?	☒	☐
JOINT AND JOINT QUESTIONS	Yes	No	44. Have you had any eye injuries?	☒	☐
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?	☐	☒	45. Do you wear glasses or contact lenses?	☒	☐
18. Have you ever had any broken or fractured bones or dislocated joints?	☐	☒	46. Do you wear protective eyewear, such as goggles or a face shield?	☐	☒
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?	☐	☒	47. Do you worry about your weight?	☐	☒
20. Have you ever had a stress fracture?	☐	☒	48. Are you trying to or has anyone recommended that you gain or lose weight?	☐	☒
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)	☐	☒	49. Are you on a special diet or do you avoid certain types of foods?	☐	☒
22. Do you regularly use a brace, orthotics, or other assistive device?	☒	☐	50. Have you ever had an eating disorder?	☐	☒
23. Do you have a bone, muscle, or joint injury that bothers you?	☐	☒	51. Do you have any concerns that you would like to discuss with a doctor?	☐	☒
24. Do any of your joints become painful, swollen, feel warm, or look red?	☐	☒	FEMALES ONLY		
25. Do you have any history of juvenile arthritis or connective tissue disease?	☐	☒	52. Have you ever had a menstrual period?	☒	☐

Explain "yes" answers here

43 - Wearing corrective glasses

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

Signature of athlete

Signature of parent/guardian

Date

9-1-2017

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■ PREPARTICIPATION PHYSICAL EVALUATION THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam _____
 Name _____ Date of birth _____
 Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

1. Type of disability		
2. Date of disability		
3. Classification (if available)		
4. Cause of disability (birth, disease, accident/trauma, other)		
5. List the sports you are interested in playing		
	Yes	No
6. Do you regularly use a brace, assistive device, or prosthetic?	☐	☐
7. Do you use any special brace or assistive device for sports?	☐	☐
8. Do you have any rashes, pressure sores, or any 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 with 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 if you have ever had any of the following.

	Yes	No
Atlantoaxial instability	☐	☐
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 bilda	☐	☐
Latex allergy	☐	☐

Explain "yes" answers here

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

Signature of athlete _____ Signature of parent/guardian _____ Date _____