

■ 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) Carol Stewart CRNP Date 9/7/17

Address _____ Phone _____

Signature of physician, APN, PA Carol Stewart CRNP / Amy Morris RN

Completed Cardiac Assessment Professional Development Module

Date _____ Signature _____

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 6-14).

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 <u>20/30</u> L <u>20/30</u> Corrected ☒ Y ☐ N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan 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, linea corporis	✓	
Neurologic*	✓	
MUSCULOSKELETAL	✓	
Neck	✓	
Back	✓	
Shoulder/arm	✓	
Elbow/wrist	✓	
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 lipid panel 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, CRNP Date 9-5-17
Address Auburn Montgomery High School Phone 204-244-3281
Signature of physician, APN, PA [Signature]

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: American Academy of Pediatrics, New Jersey Chapter
New Jersey Academy of Family Physicians
New Jersey Department of Health

SECTION I - TO BE COMPLETED BY PARENT(S)					
Child's Name (Last) Alkanat		Child's Name (First) Ela		Gender ☐ Male ☒ Female	Date of Birth 12 / 19 / 2009
Does Child Have Health Insurance? ☒ Yes ☐ No		If Yes, Name of Child's Health Insurance Carrier BCBS of Alabama (valid until 9.30.2017)			
Parent/Guardian Name Gokhan Alkanat		Home Telephone Number 334-669 0371		Work Telephone/Cell Phone Number 334-669 0371	
Parent/Guardian Name Gulu C. Alkanat		Home Telephone Number 334-669 0371		Work Telephone/Cell Phone Number 334 669 0371	
I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.					
Signature/Date <i>[Signature]</i> 9.1.2017				This form may be released to WIC. ☒ Yes ☐ No	
SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER					
Date of Physical Examination: 9-5-17		Results of physical examination normal? ☒ Yes ☐ No			
Abnormalities Noted:		Weight (must be taken within 30 days for WIC) 48.2		Height (must be taken within 30 days for WIC) 48.3"	
		Head Circumference (if <2 Years)			
		Blood Pressure (if ≥3 Years)		94/62	
IMMUNIZATIONS		☐ Immunization Record Attached ☐ Date Next Immunization Due:			
MEDICAL CONDITIONS					
Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:		☐ None ☐ Special Care Plan Attached	Comments Allergies - environmental		
Medications/Treatments • List medications/treatments:		☐ None ☐ Special Care Plan Attached	Comments Claritin 5mg		
Limitations to Physical Activity • List limitations/special considerations:		☒ None ☐ Special Care Plan Attached	Comments		
Special Equipment Needs • List items necessary for daily activities		☒ None ☐ Special Care Plan Attached	Comments		
Allergies/Sensitivities • List allergies:		☐ None ☐ Special Care Plan Attached	Comments Nuts, Nutella, Fruits		
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:		☒ None ☐ Special Care Plan Attached	Comments		
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:		☒ None ☐ Special Care Plan Attached	Comments		
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:		☒ None ☐ Special Care Plan Attached	Comments		
PREVENTIVE HEALTH SCREENINGS					
Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct	9/5/17	13.0 / 37.3	Hearing	9-5-17	
Lead: ☐ Capillary ☒ Venous	9/5/17	<1mcg	Vision	9-5-17	WNL
TB (mm of Induration)	0 mm	→ 9/7/2017	Dental	14x 80	0
Other:			Developmental	9-5-17	0
Other:			Scoliosis	9-5-17	0
☒ I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.					
Name of Health Care Provider (Print) Carol M. Stewart			Health Care Provider Stamp: AUBURN UNIVERSITY MONTGOMERY STUDENT HEALTH CENTER IRMA B. MOORE HALL RM. 102 P.O. BOX 24023 MONTGOMERY, AL 36124-4023		
Signature/Date <i>[Signature]</i> Carol					