Dear Prospective Student,

Thank you for your interest in the **Medication Aide Certificate Program** at College of the Mainland. Consideration for acceptance into the program is based upon the submission of your completed application.

What is a Medication Aide?

Certified Nurse Aides, who have a strong grasp of basic patient care can further their education to become a Certified Medication Aide. A Medication Aides role includes but is not limited to:

- Providing routine daily medication to patients both oral and topical (such as cream and eye medications)
- Ensuring that the patient actually swallows the medication administered to them (this is extremely important for dementia patients or uncooperative patients)
- Reporting any changes in patient vitals, behavior or other adverse effects from medication
- Duties and responsibilities of the CNA role

Preparing students to flourish in a demanding role, the COM Certified Medication Aide Program includes a combination of classroom and clinical instruction. Students explore every system of the body from cardiovascular to skin and learn about auto immune diseases and Alzheimer's. COM's Instructors are registered and licensed registered nurses who teach from their experience. The COM program follows curriculum established by the Department of Aging and Disability Services and prepares students to pass the written state certificate exam.

Students can use the program as a stepping-stone to gain a promotion at their current place of employment or to further their education toward becoming a licensed vocational nurse.

Do I need a High School Diploma or GED?

YES; A High school diploma or GED is <u>required</u> to participate in the Medication Aide training program and may be required for Financial Aid application as well as employment at various nursing and medical facilities.

How do I begin?

Interested students must apply to the Medication Aide training program by submitting, in person, all required application documents to the CE Allied Health Department located at 200 Parker Court, League City, Texas 77573. **Please note: INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED.** Also, approval of an application does <u>NOT</u> guarantee a student a place in the class, it only gives the ability to register *Pending Space Availability*. Please contact Nichole Sullivan at (409) 933-8645 if you have questions.

Registration

Only applicants that have been approved for the program will be allowed to register. Registration with an approved form MUST be done in person through the CE Office located at the Main Texas City Campus, 1200 Amburn Rd. TVB-1475, Texas City, Texas 77591. For more information please call (409) 933-8586. Registration is a first come, first served basis. Classes may be closed due to maximum enrollment or cancel without notice. Therefore, students are encouraged to register early.

Financial Aid

Financial Aid may be available for the Medication Aide training program if the student qualifies and if there is funding available. Continuing Education students may apply for the **Texas Public Education Grant (TPEG-NC)**. The TPEG-NC covers a portion of <u>tuition fees only</u> (typically 50%) & is a ONE TIME ONLY grant that is available to those students demonstrating a financial need. The remaining portion of the balance is the student responsibility and is due at the time of registration. <u>All application</u> <u>requirements for TPEG MUST be completed at least (2) two weeks prior to class start date</u>. For questions regarding financial assistance, please contact Student Financial Services at (409) 933-8466.

Students: Check your COM email!

Beginning Spring 2016 all COM business will be administered your COM email address. Students will need to setup their COM email account in order to receive any communication from the Financial Aid office, business office, Instructors or other. <u>Personal email addresses will not be used for College</u> <u>correspondence</u>. From the COM Home page click on Information Technology under College Operations. From the left menu you can find all information under Get Connected. Direct links: http://its.com.edu/login-information http://its.com.edu/email For more information contact IT at (409) 933-8302.

Applicant: Please retain this page for your records. It does not need to be turned in with your application. Thank you!



Medication Aide - Student Requirements:

(Please fill out legibly and completely)

Desired Class Date:			Session: CEQ	
Name:				
DOB:			Age:	
Address:				
City:	, Texas	Zip:		
Phone #:		Alt #:		
Email:				
In Case of Emergency, Please Contact	:			
Name (please print)	Relation to St	udent	Phone Number	
	Đ		ED	
STAFF VERIFICATION:		ſ	DATE:	
COMMENTS:				



Students entering the Medication Aide program must meet the following minimum requirements:

• MUST be at least 18 years of age

shot records MUST include:

 Able to read, write, speak and understand English (THIS PAGE TO BE COMPLETED BY COM STAFF ONLY)

Required Immunizations document signed and dated by your Healthcare Provider and accompanying

0	<i>Hepatitis B (3 shots)</i> ,,, (to be completed by COM Staff ONLY)				
0	<i>Tdap (within the last 10 years)</i> (to be completed by COM Staff ONLY)				
0	MMR (2 shots),, (to be completed by COM Staff ONLY)				
0	Varicella (2 shots)/TITER,, (to be completed by COM Staff ONLY)				
0	<i>TB Skin Test Negative (within 12 months)</i> (to be completed by COM Staff ONLY)				
0	Negative <u>10</u> Panel Drug Screen Test w/list of items tested for (within 12 months) [Drug panels that are less than 10 panel will NOT be accepted]				
0	Completed and Signed Student Acknowledgement of Hepatitis B form				
0	Completed and Signed Documenting History of Varicella form				
0	Signed Student Release Acknowledgement Form				
0	Current COM Healthcare Physical document completed and signed and dated by your Healthcare Provider (no older than 12 months)				
0	 Provide High School Diploma or GED Accepted: Certified Copy or photocopy which has been <u>NOTARIZED</u> as a true copy of an unaltered original of a high school graduation diploma, high school transcript, or a GED diploma 				
	 Diplomas from Internet Based schools <u>will not</u> be accepted Applicants who attended school outside of the country MUST have their documentation verified as being equivalent to high school graduation in the U.S. 				
	verment as being equivalent to high school graduation in the 0.3.				



- <u>MUST</u> be employed as a CNA listed on the Texas Nurse Aide Registry in active status and currently employed in a facility licensed under Texas Health & Safety Code Chapter 242 <u>on class</u> <u>start date</u> –OR Employed on class start date as a non-licensed direct care staff in a facility licensed under Chapter 247; a state supported living center or an intermediate care facility for persons with an intellectual disability and have 90 days previous employment in the year preceding the class start date. <u>THIS DOES NOT INCLUDE HOME HEALTH AGENCIES, HOSPITALS, SNF UNITS IN HOSPITALS, STAFFING AGENCIES, ADULT DAY CARE, JAIL OR TDCJ PRISONS.</u>
- Copy of signed Social Security Card (MUST match Photo ID)
- Copy of Driver's License or Government Issued Photo ID (MUST match Social Security Card) [Expired ID will not be accepted]
- O <u>NOTARIZED</u> Experience Documentation Report Form (form may not be notarized before the first day of class)
 - Texas DADS Medication Aide Program application (will be given in class and <u>MUST</u> be **notarized**)
 - Money Order payable to the Texas Department of Aging & Disability Services (DADS) in the amount of \$25



PHYSICAL EXAM & IMMUNIZATION DOCUMENTATION

All Sections are to be Completed ONLY by Healthcare Professional

(STUDENTS ARE NOT TO COMPLETE ANY PART OF THIS FORM)

Student's Name

Last	M/I	First			Sex	DOB: (DD/MM/YYYY)
						/ /
Weight	Height		Pulse	Temp	Blood Pr S	essure D

List any current illnesses or injuries:		
Is student currently pregnant:	If so, what is the due date:_	
List any permanent medical condition	ns or physical limitations:	

Medical History: (Check if applicable)

Asthma	Heart Disease	Tuberculosis	Measles
Diabetes	Seizures	Emphysema	Hypoglycemic
Hepatitis	Rheumatism	Small Pox	Tuberculosis
Diphtheria	Influenza	Pneumonia	Infantile Paralysis
Osteoarthritis	Mumps	Other	(Please specify)

(If checked above please explain): ______

1	Tests: (*Attach proof of finding)						
((Please attach proof of results. Must be no more than 1 year old to the date of the class. If results are positive, a chest x-ray is required)						
	TB Skin Test	Date read	Initials	TB Chest X-ray	Date read	Initials	
	Pos Neg			Pos Neg			

(*Attach proof of finding)

Immunizations (Give most recent date)

Hepatitis B (3 shots)	Tdap (w/in last 10 yrs)	MMR (2 shots)	Varicella (2 shots)/Titer
1			
2			
3			

I certify that I have examined this individual and he/she is suitable physically and emotionally to participate in the CE Allied Health MEDICATION AIDE Program to which they are applying for:

Yes No (If no, please explain)

Date:

Signature

M.D.

Address & Office Phone

Student Release Agreement & Applicant Statement Acknowledgement for Medication Aides

Release Agreement

While caring for patients during my clinical rotations, I hereby release and discharge College of the Mainland and all its employees from all liability for all injury, exposure or damage arising from health risks of caring for patients during my clinical rotation or during scheduled class or skills lab. I understand that I may be exposed to communicable diseases *(including blood-borne pathogens)* or personal injury. I am aware of the health risks of caring for such patients. *Please initial.*

Immunization Acknowledgement

I am also aware that the College of the Mainland CE Allied Health Department, which oversees the Medication Aide Program, requires that I have the required immunizations before my clinical rotations. I understand that I will not be allowed to enter the clinical facility for clinical purposes if I do not have the required immunizations. *Please initial.*

Applicant's Statement

I certify that I have read the above statements and that initialing my name means that I agree with the above statements. If accepted into the College of the Mainland Medication Aide Program, I agree to abide by the rules set forth by the school and the program.

Student Signature: _____



STUDENT ACKNOWLEDGEMENT OF HEPATITIS B VACCINE

Department of State Health Services Disease Prevention & Intervention Section Immunization Branch

POLICY STATEMENT 1.0 Completion of Hepatitis B vaccine series prior to direct patient care

The Texas Department of State Health Services (DSHS) rule §97.64, "Required Vaccinations for Students Enrolled in Health-Related and Veterinary Courses in Institutions of Higher Education" [25TAC§97.64, April 2004], requires students enrolled in health-related courses, which will involve direct patient contact in medical or dental care facilities to **complete a three dose series of hepatitis B vaccine prior to direct patient care**. This rule applies to all medical interns, residents, fellows, nursing students, and others who are being trained in medical schools, hospitals, and health science centers and students attending two-year and four-year colleges whose course work involves direct patient contact regardless of the number of courses taken, number of hours taken, and the classification of student.

Website for Texas Department of State Health Services Adult Immunizations Schedule: http://www.dshs.state.tx.us/immunize/adult_sched.shtm

Please check one of the following boxes as it applies to your Hepatitis B series:

I have completed the Hepatitis B 3 shot series

I only have 1 shot remaining of the 3 shot series: 3rd shot due ______

I have completed my first shot and the dates for the next two shots are: and

Based upon the clinical/extern site rules and regulations I understand & acknowledge that if I have not completed the Hepatitis B 3 shot series, I may not be able to participate in the clinical/externship portion of the program.

I have read and understand the Texas Department of State Health Services policy on Hepatitis B vaccine series. https://www.dshs.state.tx.us/immunize/docs/school/hepB_Policy.pdf

Student Printed Name

Student Signature

Completed applications are to be returned to Nichole Sullivan, Administrative Assistant CE Allied Health 200 Parker Court League City, Texas 77573 409-933-8645

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Documenting History of Illness: Varicella (Chickenpox)

This form summarizes the "Exceptions to Immunization Requirements (Verification of Immunity/History of Illness) for Varicella (Chickenpox)."

A written statement from a parent (or legal guardian or managing conservator), or physician attesting to the student's positive history of varicella disease (chickenpox), or of varicella immunity, is acceptable in lieu of a vaccine record for that disease. College of the Mainland shall accurately record the existence of any statements attesting to previous varicella illness or the results of any serologic tests supplied as proof of immunity. If a student is unable to submit such a statement or serologic evidence, varicella vaccine is required.

Documentation of prior varicella illness can be provided by the following methods:

- 1. A serologic confirmation of varicella immunity (positive varicella IgG result).
- 2. A written statement from a physician or the student's parent or guardian containing

wording such as: "This is to verify		had varicella
	(Printed name of Student)	
disease (chickenpox) on or about _		_ and does not need
· · · · · ·	(Approximate month/year)	_
the varicella vaccine."		

(Printed name of person completing form)

(Signature of person completing form)

(Relationship to student)

(Date)



For more information about Varicella contact: Texas Department of State Health Services Immunization Branch (800) 252-9152 www.ImmunizeTexas.com

8	College of the Mainland.	Continuing Education All 200 Parker Court, League C Ph. 409.933.8645 www.c	ity, Tx 77573
	EXPIERENCE DOCUMENT TEXAS DEPARTMENT OF AGIN MEDICATION AIDE PROG P.O. BOX AUSTON, TEXAS	NG & DISABILITY SERVICES RAM - MAIL CODE E416 & 149030	
APPLIC	CANT	SOCIAL SECURITY#	
	ING SCHOOL		
Form m	must filled out in its entirety by the mation submitted is correct.		
I,(F2	FACITLITY ADMINISTRATOR/PROGRAM DIRECTOR/DO	, certify that I have N	employed
	(Applicant)	to	
facilit nurse a Health non-lic nurse o	hat I know of my own knowledge that sai ity which is licensed under Health & Sa aide; or in this facility which is a l h & Safety Chapter 247, or in this Stat icensed direct care staff person under on duty or on call. Place of Employment	afety Code Chapter 242, as licensed Personal Care Fac te Supported Living Center that direct supervision o	a certified ility under , ICF-IDD as a f a licensed
2.	Address		
	Street No. City	State	Zip
3.	Phone Number (including area code)		
4.	Type of Facility		
5.	Job Title of Applicant		
б.	Nurse Aide Certificate Number (if appl Expiration Date		
7.	Type of Work Performed (be specific)		
	is day of, tify under penalty of perjury that the		
		ATURE OF ADMINISTRATOR/PROGRA	
	e me, a Notary Public in nally appeared	, known to me t	
	(ADMINISTRATOR/PROGRAM DIR name is subscribed to the foregoing ir e executed the same for the purposes ar	nstrument and acknowledged	
Given ı	under my hand and seal of office this	day of	, 20

(Signature of Notary)