NURSING PORTAL CLINICAL DOCUMENTATION CHECKLIST:

All documentation **must** be PDF scanned files from a flatbed scanner. Do not take a photo of the immunization to upload it. Scanner apps from mobile devices are not acceptable.

NOTE: The Tdap, TB and CPR cannot expire at any time during the semester you are seeking admission into.

- ☐ Hepatitis B (3 series AND a Positive Titer result)
- ☐ MMR (2 shots and/or a Positive Titer result)
- ☐ Varicella (2 shots and/or a Positive Titer result)
- ☐ Hepatitis C Screen (Negative Screen result)
- ☐ Tdap Vaccine (within the past 10 years)
- ☐ TB (must be negative within the past year)
- ☐ Seasonal Flu Vaccine (must be current season)
- ☐ Nursing Physical Assessment Form (see attached)
- ☐ FERPA Consent Form (see attached)
- ☐ Health Insurance Form (see attached)
- ☐ Health Insurance Card (both sides of card)
- ☐ Texas Driver’s License (both sides of card)
- ☐ America Heart Association BLS CPR Card (both sides of card)

College of the Mainland

Nursing Physical Assessment Form

Name:____ Birth Date:______/______/______

Last First Middle

In case of emergency, please notify: ____

Last First (Relationship) (Phone number)

Medical Provider: *College of the Mainland Nursing Program requires a physical examination by a licensed physician/health care provider. Please evaluate the student's ability to meet the following standards:*

Yes	No	
☐	☐	**Does this student have sufficient ability to communicate with healthcare professionals and patients?** The student must have the ability to explain treatment procedures, patient education, prompt communication with healthcare providers, and document nursing actions.
☐	☐	**Does this student have sufficient gross and fine motor coordination?** The student must have the ability to manipulate equipment, aspirate medications using calibrated syringes of one-hundredth increments, palpate, stoop, reach, twist, balance, bend, and lift under emergency conditions.
☐	☐	**Does this student have satisfactory physical strength and endurance?** The student must be able to move immobile patients with assistance, lift/carry/balance up to 25 pounds while walking, and be able to walk frequently during a 12-hour clinical shift.
☐	☐	**Does this student have sufficient physical ability to move from room to room and in small spaces?** The student must be able to walk around in a patient's room, work in small spaces, and small treatment areas.
☐	☐	**Does this student have satisfactory psychological function?** The student must have the ability to ensure safety of self, patient, and colleagues; function in confined spaces, and maintain self-control in emotionally charged situations.
☐	☐	**Does this student have sufficient auditory ability to monitor and assess a patient's health needs?** The student must have the ability to hear monitoring devices and alarms, to hear a patient's cries for help, and distinguish sounds through a stethoscope.
☐	☐	**Does this student have sufficient visual ability for observation and assessment necessary for patient care?** The student must have the ability to observe a patient, view calibrated syringes for aspirating medications, and observe a patient's response to interventions?

Remarks: ____

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Statement of Health Status: After careful physical examination, it is my opinion that this student is physically and psychologically able to perform the requirements for the nursing program.

Name/Title Printed:______________________________________ Date:________________
Healthcare Provider

Signature/Title:____ Date:________________
Healthcare Provider

Name of Facility ____ Date:________________

FERPA CONSENT TO RELEASE STUDENT INFORMATION

TO: _____________College of the Mainland Nursing Department_________________
(Name of University Official and Department that will be releasing the educational records)

Please provide information from the educational records of_________________________________
[**Name of Student** requesting the release of educational records] to:

_________Clinical Agencies____________[Name(s) of person or organization to whom the educational records will be released.

The only type of information that is to be released under this consent is (select all for clinical purposes):

_____ Immunizations
_____ CPR Card
_____ Clear or unclear background check
_____ Recommendations for employment or admission to other schools
_____ Clear drug screen
_____ Social Security Verification
_____ Texas Driver's License Verification and/or copy
_____ Physical Exam
_____ Other (specify) ____

The information is to be released for the following purpose:
__✓__ placement in affiliated organization to complete clinicals.

I understand the information may be released orally or in the form of copies of written records, as preferred by the requester. I have a right to inspect any written records released pursuant to this Consent. I understand I may revoke this Consent upon providing written notice to College of the Mainland Nursing Department [Name of Person listed above as the University Official permitted to release the educational records]. I further understand that until this revocation is made, this consent shall remain in effect and my educational records will continue to be provided to the person or organization named above for the specific purpose described above.

Name (print)______________________________

Signature_________________________________

Student ID Number_________________________

Date_______________________________________

College of the Mainland

Nursing Student Health Insurance Form

Students in the COM Nursing Programs are required to have a form of health insurance. You must carry proof of health insurance at all times during clinical rotations. Please fill out the form below, and upload this document and proof of health insurance coverage to the Nursing Student Portal. Health insurance coverage cannot expire at any time while in the program. Failure to comply may result in disciplinary action up to dismissal from your nursing program track. Providing invalid documents will result in disciplinary action up to dismissal from your nursing program track.

You may call or email the nursing department at (409) 933-8425 or nursing@com.edu if you have questions or concerns regarding nursing student health insurance coverage.

Health Insurance Coverage:

Student Name: ____________________

Name of Insurance Carrier: __________________

Group Number: _________________

ID Number: ____________________

_______________________ ____________________

Student Name (Printed) Date

________________________ ___________________

Student Signature Date