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 Verification Form
- ☐ MMR Verification Form
- ☐ Varicella Verification Form
- ☐ Hepatitis C Screen Verification Form
- ☐ Tdap Vaccine Verification Form
- ☐ TB Verification Form
- ☐ Flu Vaccine Verification Form
- ☐ Nursing Physical Assessment Form
- ☐ FERPA Consent Form
- ☐ Health Insurance Form
- ☐ 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)

HEPATITIS B VACCINE VERIFICATION FORM
COLLEGE OF THE MAINLAND
NURSING PROGRAMS

Complete series (3 doses) AND a HBsAg positive titer after the series is completed are required.

To be completed by Student

Name (Please Print) _____ Date of Birth_____

COM ID_____

To be completed by Provider administering Hepatitis B Vaccine

#1 Dose Date: _____

MD, PA, RN or APRN signature _____ Phone number_____

Please print your name: _____ Date: _____

Office/Clinic name and address: _____

_____

By signing this, I confirm that the information given on this form is true, complete and accurate.

#2 Dose Date: _____

MD, PA, RN or APRN signature _____ Phone number_____

Please print your name: _____ Date: _____

Office/Clinic name and address: _____

_____

By signing this, I confirm that the information given on this form is true, complete and accurate.

#3 Dose Date: _____

MD, PA, RN or APRN signature _____ Phone number_____

Please print your name: _____ Date: _____

Office/Clinic name and address: _____

_____

By signing this, I confirm that the information given on this form is true, complete and accurate.

Series 1 Titer

HBsAg Titer Date: _____ Result: _____ *(Titer completed 6-8 weeks after 3rd immunization)*

MD, PA, RN or APRN signature _____ Phone number_____

Please print your name: _____ Date: _____

Office/Clinic name and address: _____

_____

By signing this, I confirm that the information given on this form is true, complete and accurate.

HEPATITIS B VACCINE VERIFICATION FORM con't.
COLLEGE OF THE MAINLAND
NURSING PROGAMS

IF the first Titer was negative, a second series (3 doses) will be required* AND *a second HBsAg positive titer after the series is completed will be required. Please fill out the following section if applicable.

To be completed by Student

Name (Please Print) _____ Date of Birth_____

COM ID_____

To be completed by Provider administering Hepatitis B Vaccine

#4 Dose Date: _____

MD, PA, RN or APRN signature _____ Phone number_____

Please print your name: _____ Date: _____

Office/Clinic name and address: _____

_____

By signing this, I confirm that the information given on this form is true, complete and accurate.

#5 Dose Date: _____

MD, PA, RN or APRN signature _____ Phone number_____

Please print your name: _____ Date: _____

Office/Clinic name and address: _____

_____

By signing this, I confirm that the information given on this form is true, complete and accurate.

#6 Dose Date: _____

MD, PA, RN or APRN signature _____ Phone number_____

Please print your name: _____ Date: _____

Office/Clinic name and address: _____

_____

By signing this, I confirm that the information given on this form is true, complete and accurate.

Series 2 Titer

HBsAg Titer Date: _____ Result: _____ *(Titer completed 6-8 weeks after 3rd immunization)*

MD, PA, RN or APRN signature _____ Phone number_____

Please print your name: _____ Date: _____

Office/Clinic name and address: _____

_____

By signing this, I confirm that the information given on this form is true, complete and accurate.

HEPATITIS B VACCINE VERIFICATION FORM con't.
COLLEGE OF THE MAINLAND
NURSING PROGAMS

IF the second Titer was negative, a booster will be required AND a third HBsAg positive titer after the booster is completed will be required. Please fill out the following section if applicable.

To be completed by Student

Name (Please Print) _____ Date of Birth_____

COM ID_____

To be completed by Provider administering Hepatitis B Vaccine

Hepatitis B Booster Date: _____

MD, PA, RN or APRN signature _____ Phone number_____

Please print your name: _____ Date: _____

Office/Clinic name and address: _____

_____

By signing this, I confirm that the information given on this form is true, complete and accurate.

Series 3 Titer
HBsAg Titer Date: _____ Result: _____ *(Titer completed 6-8 weeks after booster)*

MD, PA, RN or APRN signature _____ Phone number_____

Please print your name: _____ Date: _____

Office/Clinic name and address: _____

_____

By signing this, I confirm that the information given on this form is true, complete and accurate.

IF the third Titer is negative, a letter of non-conversion will be required by your primary care provider.

MMR VACCINE VERIFICATION FORM
COLLEGE OF THE MAINLAND
NURSING PROGRAMS

Requirement: Two doses or report of Ab IgG positive titer following report of illness is required for all students.

To be completed by Student

Name (Please Print) _____ Date of Birth_____

COM ID_____

To be completed by Provider administering MMR Vaccine

MMR (measles, mumps & rubella)

#1 Dose Date _____

MD, PA, RN or APRN signature _____ Phone number_____

Please print your name: _____ Date: _____

Office/Clinic name and address: _____

_____

By signing this, I confirm that the information given on this form is true, complete and accurate.

#2 Dose Date_____

MD, PA, RN or APRN signature: _____ Phone number: _____

Please print your name: _____ Date: _____

Office/Clinic name and address: _____

_____

By signing this, I confirm that the information given on this form is true, complete and accurate

OR

Ab IgG Titer Date _____ Result _____

MD, PA, RN or APRN signature _____ Phone number _____

Please print your name: _____ Date: _____

Office/Clinic name and address: _____

_____

By signing this, I confirm that the information given on this form is true, complete and accurate.

VARICELLA VACCINE VERIFICATION FORM
COLLEGE OF THE MAINLAND
NURSING PROGRAMS

Requirement: Two doses or report of Ab IgG positive titer following report of illness is required for all students.

To be completed by Student

Name (Please Print) _____ Date of Birth_____

COM ID_____

To be completed by Provider administering Varicella Vaccine

Varicella (chicken pox)

#1 Dose Date: _____

MD, PA, RN or APRN signature: _____ Phone number: _____

Please print your name: _____ Date: _____

Office/Clinic name and address: _____

_____

By signing this, I confirm that the information given on this form is true, complete and accurate

Varicella (chicken pox)

#2 Dose Date: _____

MD, PA, RN or APRN signature: _____ Phone number: _____

Please print your name: _____ Date: _____

Office/Clinic name and address: _____

_____

By signing this, I confirm that the information given on this form is true, complete and accurate

OR

Varicella (chicken pox)

Ab IgG Titer Date: _____ Result: _____

MD, PA, RN or APRN signature: _____ Phone number: _____

Please print your name: _____ Date: _____

Office/Clinic name and address: _____

_____

By signing this, I confirm that the information given on this form is true, complete and accurate

HEPATITIS C SCREEN VERIFICATION FORM
COLLEGE OF THE MAINLAND
NURSING PROGRAMS

A negative Hepatitis C screen is required.

To be completed by Student

Name (Please Print) _____

Date of Birth_____

COM ID_____

To be completed by Provider administering Hepatitis C Screen

Hepatitis C Screen

HCV Date: _____ Result: _____

MD, PA, or RN signature: _____ Phone number: _____

Please print your name: _____ Date: _____

Office/Clinic name and address: _____

_____

By signing this, I confirm that the information given on this form is true, complete and accurate.

TDAP VACCINE VERIFICATION FORM
COLLEGE OF THE MAINLAND
NURSING PROGRAMS

To be completed by Student

Name (Please Print) _____ Date of Birth_____

COM ID_____

To be completed by Provider administering Tdap Vaccine

Note This Must Be Tdap, Not Td or DTaP

One dose within the last 10 years is required.

Date Administered _____

Lot # _____ Expiration Date _____

Administered by _____

MD, PA, RN or APRN signature _____ Phone number_____

Please print your name: _____ Date: _____

Office/Clinic name and address: _____

_____

By signing this form, I confirm that the information given on this form is true, complete and accurate.

TB VERIFICATION FORM
COLLEGE OF THE MAINLAND
NURSING PROGRAMS

A negative PPD reading or QuantiFERON Gold within the last year is required. If there is a history of a positive PPD or QuantiFERON Gold, a report of a negative chest x-ray taken after the positive PPD or QuantiFERON Gold and within the last 5 years is required.

To be completed by Student

Name (Please Print) _____

Date of Birth_____

COM ID_____

To be completed Provider administering TB Skin Test

Date TB test was administered _____

Date TB test result was read_____ Read by _____

RESULT: Positive _____ Negative _____

MD, PA, RN or APRN signature _____ Phone number_____

Please print your name: _____ Date: _____

Office/Clinic name and address: _____

_____

By signing this, I confirm that the information given on this form is true, complete and accurate.

OR

QuantiFERON Gold Date _____

RESULT: Positive _____ Negative _____

MD, PA, RN or APRN signature _____ Phone number_____

Please print your name: _____ Date: _____

Office/Clinic name and address: _____

_____

By signing this, I confirm that the information given on this form is true, complete and accurate.

If there is a history of a positive PPD or QuantiFERON Gold, a report of a negative chest x-ray taken after the positive PPD or QuantiFERON Gold and within the last 5 years is required.

Chest X-Ray Date: _____Result_____

MD, PA, RN or APRN signature _____ Phone number_____

Please print your name: _____ Date: _____

Office/Clinic name and address: _____

_____

By signing this, I confirm that the information given on this form is true, complete and accurate.

FLU VACCINE VERIFICATION FORM
COLLEGE OF THE MAINLAND
NURSING PROGRAMS

To be completed by Student

Name (Please Print) _____ Date of Birth_____

COM ID_____

To be completed by Provider administering Flu Vaccine

One dose of the current seasonal flu required annually,

Date Administered _____

Lot # _____ Expiration Date _____

Administered by _____

MD, PA, RN or APRN signature _____ Phone number_____

Please print your name: _____ Date: _____

Office/Clinic name and address: _____

_____

By signing this, I confirm that the information given on this form is true, complete and accurate.

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: _____

_____

_____

_____

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