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 HBsAb positive titer after the series is completed are required.

<table>
<thead>
<tr>
<th>To be completed by Student</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name (Please Print) _______________________________ Date of Birth _______________________________</td>
</tr>
<tr>
<td>COM ID _______________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>To be completed by Provider administering Hepatitis B Vaccine</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1 Dose Date: ___________</td>
</tr>
<tr>
<td>MD, PA, RN or APRN signature _______________________________ Phone number ________________</td>
</tr>
<tr>
<td>Please print your name: _______________________________ Date: ________________</td>
</tr>
<tr>
<td>Office/Clinic name and address: _______________________________</td>
</tr>
<tr>
<td>By signing this, I confirm that the information given on this form is true, complete and accurate.</td>
</tr>
</tbody>
</table>

| #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**

<table>
<thead>
<tr>
<th>HBsAb Titer Date: ___________ Result: <strong>Positive</strong> or <strong>Negative</strong> <em>(Please Circle One)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>MD, PA, RN or APRN signature _______________________________ Phone number ________________</td>
</tr>
<tr>
<td>Please print your name: _______________________________ Date: ________________</td>
</tr>
<tr>
<td>Office/Clinic name and address: _______________________________</td>
</tr>
<tr>
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</tr>
</tbody>
</table>
HEPATITIS B VACCINE VERIFICATION FORM con’t.
COLLEGE OF THE MAINLAND
NURSING PROGAMS

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

<table>
<thead>
<tr>
<th>To be completed by Student</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name (Please Print)</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>COM ID</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>To be completed by Provider administering Hepatitis B Vaccine</th>
</tr>
</thead>
<tbody>
<tr>
<td>#4 Dose Date:</td>
</tr>
<tr>
<td>MD, PA, RN or APRN signature</td>
</tr>
<tr>
<td>Please print your name:</td>
</tr>
<tr>
<td>Office/Clinic name and address:</td>
</tr>
</tbody>
</table>

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

| #5 Dose Date:        | Phone number |
| MD, PA, RN or APRN signature |               |
| 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:        | Phone number |
| MD, PA, RN or APRN signature |               |
| 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

<table>
<thead>
<tr>
<th>HBsAb Titer Date:</th>
<th>Result:</th>
<th>Phone number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 PROGRAMS**

*If the second Titer was negative or equivocal, a booster will be required AND a third HBsAb positive titer after the booster is completed will be required. Please fill out the following section if applicable.*

<table>
<thead>
<tr>
<th>To be completed by Student</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name (Please Print) ___________________</td>
</tr>
<tr>
<td>COM ID ___________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>To be completed by Provider administering Hepatitis B Vaccine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B Booster Date: __________</td>
</tr>
<tr>
<td>MD, PA, RN or APRN signature ___________________</td>
</tr>
<tr>
<td>Please print your name: ___________________</td>
</tr>
<tr>
<td>Office/Clinic name and address: ___________________</td>
</tr>
</tbody>
</table>

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

**Series 3 Titer**

<table>
<thead>
<tr>
<th>Date: __________</th>
<th>Result: __________</th>
<th>Phone number ___________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>MD, PA, RN or APRN signature ___________________</td>
<td>Date: ___________________</td>
<td></td>
</tr>
<tr>
<td>Please print your name: ___________________</td>
<td>Date: ___________________</td>
<td></td>
</tr>
<tr>
<td>Office/Clinic name and address: ___________________</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*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.*
Revised: 4/5/19

**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.

<table>
<thead>
<tr>
<th>To be completed by Student</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name (Please Print) ____________________ Date of Birth ____________________</td>
</tr>
<tr>
<td>COM ID ____________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>To be completed by Provider administering MMR Vaccine</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMR (measles, mumps &amp; rubella)</td>
</tr>
<tr>
<td>#1 Dose Date ___________</td>
</tr>
<tr>
<td>MD, PA, RN or APRN signature _______________________ Phone number ____________________</td>
</tr>
<tr>
<td>Please print your name: __________________________ Date: ____________________</td>
</tr>
<tr>
<td>Office/Clinic name and address: ____________________</td>
</tr>
<tr>
<td>By signing this, I confirm that the information given on this form is true, complete and accurate.</td>
</tr>
<tr>
<td>#2 Dose Date ___________</td>
</tr>
<tr>
<td>MD, PA, RN or APRN signature: ______________________ Phone number: ____________________</td>
</tr>
<tr>
<td>Please print your name: __________________________ Date: ____________________</td>
</tr>
<tr>
<td>Office/Clinic name and address: ____________________</td>
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</table>

<table>
<thead>
<tr>
<th>OR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles Ab IgG Titer Date ___________ Result: Positive or Negative (Please Circle One)</td>
</tr>
<tr>
<td>Mumps Ab IgG Titer Date ___________ Result: Positive or Negative (Please Circle One)</td>
</tr>
<tr>
<td>Rubella Ab IgG Titer Date ___________ Result: Positive or Negative (Please Circle One)</td>
</tr>
<tr>
<td>MD, PA, RN or APRN signature _______________________ Phone number ____________________</td>
</tr>
<tr>
<td>Please print your name: ________________________ Date: ____________________</td>
</tr>
<tr>
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</table>
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.

<table>
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</table>

<table>
<thead>
<tr>
<th>To be completed by Provider administering Varicella Vaccine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Varicella (chicken pox)</td>
</tr>
<tr>
<td>#1 Dose Date: ___________</td>
</tr>
<tr>
<td>MD, PA, RN or APRN signature: ______________________________</td>
</tr>
<tr>
<td>Please print your name: ___________________________</td>
</tr>
<tr>
<td>Office/Clinic name and address: ___________________________</td>
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<td>By signing this, I confirm that the information given on this form is true, complete and accurate</td>
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</tbody>
</table>

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 Hepatitis C screen is required.

<table>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>To be completed by Provider administering Hepatitis C Screen</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hepatitis C Screen</strong></td>
</tr>
<tr>
<td>HCV Date: __________ Result: <strong>Positive</strong> or <strong>Negative</strong> <em>(Please Circle One)</em></td>
</tr>
<tr>
<td>MD, PA, or RN signature: ___________________________ Phone number: ____________</td>
</tr>
<tr>
<td>Please print your name: ___________________________ Date: ____________</td>
</tr>
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<td>Office/Clinic name and address: ___________________</td>
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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.
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.

<table>
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<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>To be completed Provider administering TB Skin Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date TB test was administered</td>
</tr>
<tr>
<td>Date TB test result was read</td>
</tr>
<tr>
<td>Read by</td>
</tr>
<tr>
<td>RESULT: Positive _______ Negative _______</td>
</tr>
<tr>
<td>MD, PA, RN or APRN signature</td>
</tr>
<tr>
<td>Please print your name:</td>
</tr>
<tr>
<td>Office/Clinic name and address:</td>
</tr>
</tbody>
</table>

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                          |
Please print your name:                              |
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                          |
Please print your name:                              |
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.
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:

[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 ________________________________
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