

# Hinds Community College Nursing and Allied Health Programs Clinical Record Packet



## General Directions & Information

All nursing/allied health programs utilize CastleBranch to intake students' clinical health records. CastleBranch provides colleges, universities and other education institutions nationwide a secure, web-based, environment to maintain all records required as part of the clinical records packet. Additionally, CastleBranch monitors and notifies students of any missing documents as well as notifying students reminders of when documents are set to expire. Students pay a small fee for this service, which is charged to students as part of healthcare professional fees. Students have access to all submitted documents through CastleBranch even when no longer enrolled in the college.

During orientation, students will be given information regarding the registration process for a CastleBranch account. Students will be informed by program chair/director or advisor when students may register for a CastleBranch account. **DO NOT attempt to register for a CastleBranch account until you have been notified by your chair/director or advisor.**

Using a login and password to access the CastleBranch student portal, students will be required to upload clinical requirement documents to the student's account by the program's designated due date. Failure to submit all documents required as part of the Clinical Record Packet by the designated due date will result in disruption in progression. Attendance guidelines will be enforced for any time missed due to lack of complete clinical requirements. For questions about program deadline dates or satisfactory completion of requirements, contact the appropriate program representative provided on the list on page 2 of this packet.

Uploading your documents is easiest by scanning and uploading. Scanning and uploading using your cell phone is very convenient using the CamScanner mobile app, which is available through the App Store on your phone. Newer iPhones have the ability to scan documents as PDF through the Notes App. Please do not take photos of the document and upload. Directions regarding how to upload documents is available on the CastleBranch website.

Students may choose to go to any healthcare provider, clinic, etc.; however, the following healthcare agencies offer discounted pricing to Hinds Community College students for lab tests, immunizations, etc.:

- Jackson Hinds Comprehensive Health · 601-362-5321
- MedScreens, Inc. · 601-939-3030
- TrustCare Medical Express Clinics (various locations in the Jackson Metro Area)

All clinical requirements uploaded to CastleBranch must include a date that will be current for the entire semester. **Altered documents will not be accepted!**

## Program Representatives

Melissa Tillson, Program Director, NAHC  
*Associate Degree Nursing*  
601-376-4865  
[mwtillson@hindscc.edu](mailto:mwtillson@hindscc.edu)

Wendy Lingle, Assistant Director, NAHC  
*Associate Degree Nursing*  
1750 Chadwick Drive  
Jackson, MS 39204  
601-376-4861

Portia Travis, Program Director, Transition to RN  
*Associate Degree Nursing*  
1750 Chadwick Drive  
Jackson, MS 39204  
601-376-4862  
[pftravis@hindscc.edu](mailto:pftravis@hindscc.edu)

Audrey Murray, District Director for ADN,  
Nursing Director, Rankin Campus  
*Associate Degree Nursing/Practical Nursing*  
601-936-1842  
[ACMurray@hindscc.edu](mailto:ACMurray@hindscc.edu)

Tawanda McNair  
Nursing Learning Lab/Clinical Coordinator  
*Associate Degree Nursing/Practical Nursing*  
601-376-4903

Valeria Winston, Program Chair  
*Dental Assisting*  
601-376-4820  
[Valeria.Winston@hindscc.edu](mailto:Valeria.Winston@hindscc.edu)

Lesa Wilson, Program Chair  
*Diagnostic Medical Sonography*  
601-376-4821  
[lbwilson@hindscc.edu](mailto:lbwilson@hindscc.edu)

Brian Staley, Program Chair  
*Emergency Medical Technology*  
601-376-4822  
[Brian.Staley@hindscc.edu](mailto:Brian.Staley@hindscc.edu)

Jackey Sisk, Instructor  
*Healthcare Assistant*  
601-376-4848  
[Jacqueline.Sisk@hindscc.edu](mailto:Jacqueline.Sisk@hindscc.edu)

Michele McGuffee, Program Chair  
*Health Information Technology*  
601-376-4823  
[mlmcguffee@hindscc.edu](mailto:mlmcguffee@hindscc.edu)

LaJuanda Portis, Program Chair  
*Medical Laboratory Technology*  
601-376-4824  
[LaJuanda.Portis@hindscc.edu](mailto:LaJuanda.Portis@hindscc.edu)

Pam Chapman, Program Chair  
*Physical Therapist Assistant*  
601-376-4825  
[ptchapman@hindscc.edu](mailto:ptchapman@hindscc.edu)

Carol Manley,  
District Director of Practical Nursing  
*Practical Nursing*  
601-376-4850  
[camanley@hindscc.edu](mailto:camanley@hindscc.edu)

Jennifer Davis, Program Chair  
*Radiologic Technology*  
601-376-4826  
[Jennifer.Davis@hindscc.edu](mailto:Jennifer.Davis@hindscc.edu)

Therese Winschel, Program Chair  
*Respiratory Care*  
601-376-4827  
[TEWinschel@hindscc.edu](mailto:TEWinschel@hindscc.edu)

Dottie Binkley, Program Chair  
*Surgical Technology*  
601-376-4828  
[ddbinkley@hindscc.edu](mailto:ddbinkley@hindscc.edu)

Kim Neely, Health  
Continuing Education Coordinator  
*Short-Term [Nursing Assistant & Phlebotomy]  
Reorientation to Nursing*  
601-376-4958  
[Kimberly.Neely@hindscc.edu](mailto:Kimberly.Neely@hindscc.edu)

## Clinical Record Requirements Check List

The following are requirements for all students entering/continuing in nursing and allied health programs. Students are responsible for uploading all documents, with the exception of the Clinical Clearance Letter and the Drug Screen Results, to the student's account through the CastleBranch Portal.

**\*\*Do not upload any documents that expire during the semester in which you enter or are continuing. For example, if you have a TB skin test already done in October 2018, it expires in October 2019, which is during the semester. You will need to repeat your TB skin test prior to the beginning of the Fall 2019 semester.**

Hinds' Nursing/Allied Health Requirements	Item Completed	Item Uploaded
<b>Annual Requirements</b>		
<b>Completed Health History Upon Admission &amp; Annually Thereafter</b> To be completed by the student, Page 6.		
<b>Completed Physical Exam Form Upon Admission &amp; Annually Thereafter</b> To be completed by physician or certified nurse practitioner within three months prior to the published due date, i.e., if due on August 1, must have be completed no earlier than May 1 <sup>st</sup> . All areas must be completed on the Hinds Community College approved form on page 7.		
<b>TB skin test, chest x-ray (CXR) or IGRA, Upon Admission &amp; Annually Thereafter</b> A record of negative results from a 2-step TB skin test <b>within the last year</b> , CXR or IGRA (QuantiFeron Gold® or T-Spot) is required upon admission. <i>It must have been done in a time frame so that it does not expire during the middle of a semester. Note: A two-step TB skin test is required</i> for all newly admitted students. The 2 <sup>nd</sup> step of the TB skin test is given 7-21 days after the 1 <sup>st</sup> step. The entire series must be re-started if the 2 <sup>nd</sup> step is not done within 7-21 days of the first step. <b>*TB SKIN TESTS MUST BE DONE PRIOR TO OTHER VACCINES**</b>		
<b>Flu Vaccine Annually between October 1 &amp; November 1</b> Flu vaccines are required annually in the fall between September 1st and November 1 <sup>st</sup> . Students returning in the spring and summer semesters must show documentation of flu vaccine between September 1 of the previous year and the beginning of the semester. <ul style="list-style-type: none"> <li>• Students have the right to request medical or religious exemption, but the agency may not allow exemptions and has the right to deny clinical experiences to the student, or may require the student to wear a mask for an entire clinical experience.</li> <li>• A Flu Declination Statement is available for download on CastleBranch, must be completed and uploaded along with appropriate documentation of a medical or religious exemption.</li> </ul>		
<b>OSHA/HIPAA Certificates</b> Upon orientation/registration students will be given information by program director/chair regarding completion of OSHA/HIPAA modules. Upon completion students will upload completion certificates (9). These must be uploaded at one time. You will not be able to upload 1-2 certificates then come back later to upload more. <b>Satisfies CAE-2Y criteria 5a and 5b</b>		
<b>CPR: Upon Admission and Every 2 Years Thereafter</b> Proof of current American Heart Association <b>BLS Provider Certification</b> (Heart Saver courses are not acceptable) with a signed card. Both front and back of card must be uploaded. A BLS Provider eCard is also acceptable for uploading. Letters stating student has completed a BLS course and is awaiting a CPR Card will only be accepted from Hinds Community College's continuing education department and must be uploaded. Must not expire during the current semester. <b>**NAHC Healthcare Continuing Education Department holds BLS Provider Certification Courses frequently. Contact 601-376-4958 for course information. If you chose to utilize another facility for this, you must make sure you are taking the BLS Provider Certification class, NOT a HeartSaver class.</b>		

<b>Background Records Check: Upon Admission and Every 2 Years Thereafter</b> All students must complete fingerprinting and criminal background check from the Nursing/Allied Health Center within 3 weeks of the call-in or prior to the start of class for students attending late call-ins. Students who have any eliminating background record will not be allowed admission to any nursing or allied health program. Students may also be denied the ability to progress in a program of study based on eliminating background information. Students will receive information regarding signing up for fingerprinting during the call-in/orientation. For more information, review the procedure on the Nursing & Health Related Professions page of the College website: <a href="http://www.hindscc.edu/programs-of-study/nursing-and-health-related-programs/index#gsc.tab=0">http://www.hindscc.edu/programs-of-study/nursing-and-health-related-programs/index#gsc.tab=0</a> . <b>Clinical clearance letters will be uploaded to student account by the Clinical Records Clerk.</b>		
<b>One-time Submissions Upon Admission</b>		
<b>*Tetanus, Diptheria, &amp; Pertussis</b> Proof of immunization within the last 10 years for all three (3) infections, Tetanus, Diptheria, & Pertussis.		
<b>Varicella Titer or Copy of immunization record verifying proof of two Varicella immunizations.</b> Proof of two separate varicella immunizations or a positive IGG Varicella titer is <b>required</b> if there is no proof of two Varicella immunizations. If the varicella titer is negative, the student must provide proof of two separate vaccinations. <b>Note:</b> There is a waiting period of at least thirty days between the two injections.		
<b>MMR (2)</b> Proof of two MMR immunizations or proof of a positive titer for each of the following: measles, mumps and rubella. <b>Note:</b> There is a waiting period of at least thirty days between the two injections.		
<b>Hepatitis B Immunization/Immunity</b> A complete series* of three scheduled immunizations is strongly recommended for all programs. A positive Hepatitis B titer can be substituted for a complete series. Note: Students are required to upload of the following: a complete series and a positive titer, or a declination statement. The declination statement form is found on CastleBranch and must be completed and uploaded.		

**Continuing Nursing and Allied Health Students’ Clinical Requirements**

Continuing Nursing and Allied Health students that are not already enrolled in CastleBranch will be required to register for a CastleBranch account, and upload documents to the student portal. See first page regarding CastleBranch registration instructions.

Continuing Nursing and Allied Health Students are required to complete the following **annually**, (due dates will be assigned by instructors). **Do NOT upload any of these that expire during the semester in which you are continuing. These must be done prior to the start of the semester.** Students will not be allowed to participate in class, laboratory, or clinical until the annual requirements are completed:

1. An updated health history..... (Page 6)
2. A physical examination by a physician or certified nurse practitioner..... (Page 7)
3. Clinical Tests: A negative one-step TB Skin **Test if a documented prior 2-Step was done within the last year**, chest X-ray (with negative results recorded) or negative IGRA (QuantiFeron Gold or T-Spot)
4. Flu vaccine annually in the fall semester (due by November 1). Students returning in the spring and summer semesters must show documentation of flu vaccine between Oct. 1 of the previous year and the beginning of the semester. May be earlier than October 1<sup>st</sup>, upon CDC recommendations.

**Biennial (every 2 years) Requirements:**

Continuing and/or repeating nursing and allied health students are required to complete the following biennially or every 2 years. Students will not be allowed to participate in class, laboratory, or clinical until the biennial requirements are completed.

1. CPR (BLS Provider; HeartSaver is not acceptable) certification must be updated PRIOR to the start of the semester in which it expires, i.e., if CPR expires October, 2019, it must be updated prior to the start of the Fall 2019 semester.
2. Fingerprinting for Criminal Background Check must be completed PRIOR to the semester in which it expires, i.e., if Background check expires October, 2019, it must be updated prior to the start of the Fall 2019 semester. Students must make an appointment to have fingerprint done at the NAHC.

**Facts to Remember about All Immunizations:**

1. If a student is pregnant or breast feeding, immunizations may be deferred with written documentation from a physician.
2. If immunizations cannot be taken, such as for allergies, written documentation must be provided by a physician.
3. The clinical agencies may reserve the right to deny the student clinical experiences based on their policies pertaining to no. 1 and 2.
4. MMR and TB skin test can be initiated on the same day; however, the TB skin test **MUST** be administered first, or a 30 day waiting period is required between the two.
5. There is a waiting period of at least 30 days between the two Varicella injections. There must be at least 14 days between the last injection and the first clinical day.

## Health History

Name of Student: \_\_\_\_\_  
(Print) Last Middle  
First

ID# \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Email: \_\_\_\_\_  
 Current Address: \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

1. Have you ever had or do you now have the following: (Please check at left of each item) If you check "Yes", please comment below about previous/current treatment.

- | Yes No   | Yes No  | Yes No   |
|--|---|--|
| <input type="checkbox"/> <input type="checkbox"/> Chicken Pox                  | <input type="checkbox"/> <input type="checkbox"/> Tooth or Gum Problems | <input type="checkbox"/> <input type="checkbox"/> Ulcer                      |
| <input type="checkbox"/> <input type="checkbox"/> Diphtheria                   | <input type="checkbox"/> <input type="checkbox"/> Hay Fever             | <input type="checkbox"/> <input type="checkbox"/> Digestive Disturbances     |
| <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever              | <input type="checkbox"/> <input type="checkbox"/> Asthma                | <input type="checkbox"/> <input type="checkbox"/> Hernia                     |
| <input type="checkbox"/> <input type="checkbox"/> Mumps or Measles             | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis          | <input type="checkbox"/> <input type="checkbox"/> Kidney or Bladder Problems |
| <input type="checkbox"/> <input type="checkbox"/> German Measles               | <input type="checkbox"/> <input type="checkbox"/> Chronic Cough         | <input type="checkbox"/> <input type="checkbox"/> Back Problems              |
| <input type="checkbox"/> <input type="checkbox"/> Swollen/Painful Joints       | <input type="checkbox"/> <input type="checkbox"/> Shortness of Breath   | <input type="checkbox"/> <input type="checkbox"/> Arthritis                  |
| <input type="checkbox"/> <input type="checkbox"/> History of Mental Disorders  | <input type="checkbox"/> <input type="checkbox"/> Menstrual Disorders   | <input type="checkbox"/> <input type="checkbox"/> Foot Problems              |
| <input type="checkbox"/> <input type="checkbox"/> Epilepsy / Seizure Disorders | <input type="checkbox"/> <input type="checkbox"/> Chest Pain            | <input type="checkbox"/> <input type="checkbox"/> Diabetes                   |
| <input type="checkbox"/> <input type="checkbox"/> Frequent Severe Headaches    | <input type="checkbox"/> <input type="checkbox"/> Heart Disease         | <input type="checkbox"/> <input type="checkbox"/> Speech Difficulties        |
| <input type="checkbox"/> <input type="checkbox"/> Eye Problems                 | <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> <input type="checkbox"/> Hearing Difficulties       |
| <input type="checkbox"/> <input type="checkbox"/> Glasses/Contact Lenses       | <input type="checkbox"/> <input type="checkbox"/> Varicose Veins        | <input type="checkbox"/> <input type="checkbox"/> Skin Disorders             |
| <input type="checkbox"/> <input type="checkbox"/> Ear/Nose/Throat Problems     | <input type="checkbox"/> <input type="checkbox"/> Excessive Bleeding    | <input type="checkbox"/> <input type="checkbox"/> Venereal Disease           |
| <input type="checkbox"/> <input type="checkbox"/> Hearing Aids                 | <input type="checkbox"/> <input type="checkbox"/> Jaundice              | <input type="checkbox"/> <input type="checkbox"/> Excessive Weight Loss      |

Comments: \_\_\_\_\_  
 \_\_\_\_\_

2. Allergies (food, medication, latex, etc.) \_\_\_\_\_  
 3. Current Medications: Name and Dosage (Attach a separate sheet listing all medications, if too many to list below)


4. Drug or Alcohol Rehabilitation: \_\_\_\_\_  
 5. Surgical Operations: \_\_\_\_\_  
 \_\_\_\_\_  
 6. Accidents or Injuries: \_\_\_\_\_  
 7. Other Health Problems: \_\_\_\_\_  
 \_\_\_\_\_

I certify that I have reviewed the information recorded and that it is true and complete to the best of my knowledge.

Date: \_\_\_\_\_ Signed: \_\_\_\_\_

## Physical Exam Form

Student Name: \_\_\_\_\_ ID#: \_\_\_\_\_ Program: \_\_\_\_\_ Campus: \_\_\_\_\_

*To be completed by a physician or certified nurse practitioner*

<b>Vital Signs:</b>		B/P _____	PR _____	Height _____	Weight _____
<b>General Appearance</b>	<b>Neck / Head</b>	<b>Peripheral Vascular</b>			
<b>Eyes</b>	<b>Chest</b>	<b>Musculoskeletal</b>			
<b>Visual Acuity</b>	<b>Lungs</b>	<b>Neurological</b>			
<b>Ears</b>	<b>Heart</b>	<b>Skin</b>			
<b>Auditory Acuity</b>	<b>Abdomen</b>				
<b>Nose/Throat</b>	<b>Nutritional Status</b>				

**Current Medications and/or Treatment** (Attach a separate list if too many to list below)


**Remarks / Special Recommendations** \_\_\_\_\_

**Physician's/Nurse Practitioner's (Please Print)**

**Name** \_\_\_\_\_

**Address** \_\_\_\_\_

**Phone Number** \_\_\_\_\_

<p><b>In your opinion, is there any health problem or prescribed medication which would interfere with this individual's ability to pursue a program of study that requires classroom and clinical experiences, including physical activity?</b>          ___ No ___ Yes (Explain)</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><b>Signed</b></p> <p style="text-align: center;">_____</p> <p style="text-align: center;"><b>Physician or Nurse Practitioner</b></p> <p><b>Date</b> _____</p>
---	--