

**WALLACE COMMUNITY COLLEGE  
PRACTICAL NURSING PROGRAM  
HEALTH INSURANCE FORM**

*It is recommended that all students in the Practical Nursing program have health insurance. Prior to any clinical or learning lab experience, you must either provide proof of health insurance or sign a waiver acknowledging that you are unable to provide proof of health insurance.*

I acknowledge that I have health insurance with:

\_\_\_\_\_  
Name of Insurance Company

I release Wallace Community College, its agents, and any and all affiliate clinical facilities and their agents from any liability related to injuries received or illnesses resulting while a student in the Practical Nursing program.

\_\_\_\_\_  
Printed Student Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Student ID Number

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**WAIVER**

I have been informed and understand the importance of obtaining health insurance. I am unable to show proof of health insurance and refuse to obtain any. I understand that it is my responsibility to pay for all medical expenses that result from illness or injury that may occur while a student in the Practical Nursing program.

I release Wallace Community College, its agents, and any and all affiliate clinical facilities and their agents from any liability related to injuries received or illnesses resulting while a student in the Practical Nursing program.

\_\_\_\_\_  
Printed Student Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Student ID Number