**All Residential students**

**HEALTHCARE CONSENT FORM**

Student’s Legal Name: Goes By:

Date Of Birth: Grade Level: Gender:

Student Cell Phone #: ( )

I, the parent/guardian of the above-named student, hereby delegate authority to consent to health care in my absence (pursuant to IC 16-36-1-6)

**TO:** *The Indiana Academy for Science, Mathematics, and Humanities*

*Ball State University-Wagoner Complex, 301 N. Talley, Muncie, IN 47306- (765) 285-8125*

**From:** June 1, 2024 to July 1, 2025

**Parent/Guardian Signature(s):**

Parent Name (1): (2):

Address:

City/State/Zip:

Signature(s):

Date:

**Witness Signature:**

Witness Name:

Address:

City/State/Zip:

Signature:

Date:

*The parent/guardian is responsible for all student medical expenses incurred while at the Indiana Academy of Science, Mathematics and Humanities.*