THE INDIANA ACADEMY FOR SCIENCE, MATHEMATICS, AND HUMANITIES

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, 2026 to July 1, 2027

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.

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