THE INDIANA ACADEMY FOR SCIENCE, MATHEMATICS, AND HUMANITIES

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

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

From:

June 1, 2023 to July 1, 2024

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.

Nicola Al Khatib, RN & April Smith, LPN
Fax: (765)285-0063 nalkhatib@bsu.edu