**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, 2022 to July 1, 2023

**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.*