



DARCY AMACHER, DDS

105 Akers Farm Road

Christiansburg, VA

540-394-3300

Date: _____

I, _____, parent/legal guardian of patient, _____,
give my permission for (Name of Caretaker & Relationship) _____ to bring
(Patient Name) _____ to his/her dental appointment(s), to discuss information in
regards to the patient's current oral hygiene and to make decisions for care in regards to any and all
recommended and necessary treatment beginning on this day (Month/Day/Year) _____
and ending on this date (Month/Day/Year) _____.

Signature of Parent/Legal Guardian _____

Date _____

Parent/Legal Guardian Print Name _____

Date _____