AuBurn Healthy Kids Program
Healthy Habits....Healthy Children

Fill out this form and return it to any AuBurn Pharmacy to enroll in the AuBurn Healthy Kids Program!

Parent / Guardian
Name: ______________________ Cell#: ______________

Address: ______________________

City: ______________ State: ______________ Zip Code ______________

Home Phone: ______________ Email: ______________

- ❑ Text me a monthly pick up reminder
- ❑ Email me a monthly pick up reminder
- ❑ Yes, I am interested in receiving emails about AuBurn Healthy Kids Specials & Clinics

Children in the household enrolling in this program:

1) Name: ______________ M/F___ Age: ___ D.O.B: ______
   Allergies: ______________ School: ______________

2) Name: ______________ M/F___ Age: ___ D.O.B: ______
   Allergies: ______________ School: ______________

3) Name: ______________ M/F___ Age: ___ D.O.B: ______
   Allergies: ______________ School: ______________

4) Name: ______________ M/F___ Age: ___ D.O.B: ______
   Allergies: ______________ School: ______________

Other responsible parties with permission to pick up products (18 yrs or older)

1) Name: ______________ Ph#: ______________ Relationship: ______________

2) Name: ______________ Ph#: ______________ Relationship: ______________

Signature: ______________________ Date: ______________

USE AS DIRECTED
AuBurn Pharmacy is not responsible for any misuse or dispensing of this product. This product contains SOY AND FISH Ingredients. If you have any concerns please consult your physician before taking this product.