



Schroeder's Healthy Kids Program Healthy Habits *for* Healthy Kids

Fill out this form and return it to Schroeder Drugs to enroll in the Schroeder's Healthy Kids Program!

Parent/Guardian Name: _____ D.O.B.: _____

Address: _____

City: _____ State: _____ Zip: _____

Home/Cell: _____ Email: _____

Yes / No, Please circle if you're interested in receiving email or phone call reminders about Schroeder's Healthy Kids Programs

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 (18yrs or older)

1. Name: _____ Ph# _____ Relationship: _____

2. Name: _____ Ph# _____ Relationship: _____

Signature: _____ Date: _____

Offer subject to restrictions. See store for details.