Pharmax Healthy Kids Program

Healthy Habits *for* Healthy Kids

Fill out this form and return it to any Pharmax Pharmacy to enroll in the Pharmax 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 Pharmax 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.