Claiborne Pharmacy Healthy Kid's Vitamin Program

Parent/ Guardian: _____

Phone Number: _____

Home Address: _____

_____

Email Address: _____

Claiborne PHARMACY & Gifts

Eligible Children (ages 4 - 12)

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Guadian Signature: _____ Date: _____

***By enrolling in this program you consent to receive promotional materials from Claiborne Pharmacy by phone, text or email. We respect your privacy and will not share your personal information.**

***By signing this form, you are aware that the Leader Children's Multivitamin contains milk.**