

# FREE Blood Pressure Self-Monitoring Classes

**When:**

Tuesday's 5:30 p.m.  
8 classes in person  
4 phone call follow-ups

**Where:**

Jefferson County Extension Office  
2729 West Washington Hwy  
Monticello, Florida 32344

***Classes start February 12, 2019***

**Deadline for Class Registration:**

**February 5, 2019**

**How do you sign up?**

- Complete the attached registration form
- Have your health care provider complete the attached referral form

*\* Please note, you must be clinically diagnosed with hypertension to participate in the classes\**

**Please return ALL completed forms to:**

Florida Department of Health Jefferson County  
1255 West Washington Street  
Monticello, Florida 32344

**All class participants will receive a FREE  
3-month gym membership.**

**For more information please contact:**

Chelsey McCoy  
850-342-0170 Ext. 1230 or [Chelsey.mccoy@flhealth.gov](mailto:Chelsey.mccoy@flhealth.gov)





## Registration Form

Name: _____
DOB: _____
Address: _____
Phone number: _____
Email address: _____
Emergency contact: _____
Emergency contact phone number: _____
Please list any allergies: _____

- I will request the referral form from my provider.
- I would like the Health Department to request the referral form from my provider on my behalf.

Please fill out the following information if you would like the Health Department to request your form:

<b>Provider Information:</b>
Name: _____
Address: _____
Phone: _____
Fax: _____

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Please note that in order to register for these classes and be eligible for the **FREE** gym membership you must have a referral form from your primary care physician stating you have been diagnosed with hypertension.

Gym membership is only active if you attend **ALL** scheduled "Keeping the Pressure Down" Classes.





## Physician Authorization Form

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

- Yes, my patient can participate.
- Yes, my patient can participate with the following limitations:

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- No, my patient cannot participate at this time because of his or her medical conditions and health status.

Physician's signature: \_\_\_\_\_

Print name: \_\_\_\_\_ Date: \_\_\_\_\_

Phone number: \_\_\_\_\_ Fax: \_\_\_\_\_

This form may be given to the patient or sent by fax, or mail to:

Chelsey McCoy  
1255 West Washington Street  
Monticello, Florida 32344  
(850) 342-0257 (Fax)

