

**Community Health Check Program Sign-Up Form  
Surfside Beach EMS**

---

**Date of Request:** \_\_\_\_\_

---

**1. Patient Information**

**Full Name:** \_\_\_\_\_  
**Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Gender:** \_\_\_\_\_  
**Home Address:** \_\_\_\_\_  
**City:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_  
**Primary Contact Number:** \_\_\_\_\_

---

**2. Requestor Information (if different from patient)**

**Full Name:** \_\_\_\_\_  
**Relationship to Patient:** \_\_\_\_\_  
**Contact Number:** \_\_\_\_\_

---

**3. Medical Information (as known)**

**Known Medical Conditions:**

---

---

**Medications (if known):**

---

---

---

**4. Requested Services (check all that apply):**

- ☐ Blood Pressure Check
- ☐ Heart Rate / Oxygen Level Monitoring
- ☐ Blood Glucose Testing

- ☐ General Wellness Education
  - ☐ Medication Safety Review
  - ☐ Community Resource Referral
- 

## 5. Scheduling Information

**Preferred Date/Time:** \_\_\_\_\_

**Special Instructions or Notes:**

---

---

---

**Scheduled By:** \_\_\_\_\_

**Date Scheduled:** \_\_\_\_\_

Please submit this completed form to the EMS Director at: [emsdirector@surfsidetx.org](mailto:emsdirector@surfsidetx.org).