

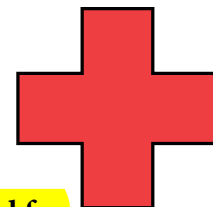


# VIAL OF L.I.F.E.

Please check and update this form monthly for accuracy!



Lifesaving Information for Emergencies



Alert! Check pharmacy on record for current information and COMPLIANCE!

Date Completed: \_\_\_\_\_ Updated: \_\_\_\_\_

## Basic Information

Name: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

In Case of Emergency, Please Notify: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

## Identifying Information

Male  Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Hair Color: \_\_\_\_\_ Eye Color: \_\_\_\_\_

Blood Type: \_\_\_\_\_ Religion: \_\_\_\_\_

Primary Language Spoken: \_\_\_\_\_ Other Language(s): \_\_\_\_\_

Glasses  Contact Lenses  False Teeth/Bridge

Hearing Aid: \_\_\_\_\_ Left \_\_\_\_\_ Right Deaf: \_\_\_\_\_ Left \_\_\_\_\_ Right

Blind: \_\_\_\_\_ Left \_\_\_\_\_ Right Artificial Eye: \_\_\_\_\_ Left \_\_\_\_\_ Right

Artificial Limbs or Prosthetic Devices: \_\_\_\_\_

Pacemaker Model #: \_\_\_\_\_ Defibrillator Model #: \_\_\_\_\_

Identifying Marks (i.e., birthmarks, tattoos, etc.): \_\_\_\_\_

Normal Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_  Smoker  Non-Smoker

## Medical History

Check Conditions that you have been treated for:

<input type="checkbox"/> Allergies	<input type="checkbox"/> Blood Pressure	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cancer	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Jaundice	<input type="checkbox"/>
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Sinus	<input type="checkbox"/>
<input type="checkbox"/> Asthma	<input type="checkbox"/> Insulin	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Stroke	<input type="checkbox"/>

Be sure to complete reverse side

# VIAL OF LIFE EMERGENCY MEDICAL INFORMATION

## Current Medical Information

Name of Doctor: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name of Doctor: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name of Pharmacy: \_\_\_\_\_ Phone #: \_\_\_\_\_

Currently Being Treated For:  
\_\_\_\_\_  
\_\_\_\_\_

\*Current Medications:

Medication	Dosage	Taken How Often? (Frequency)	Taken to treat what condition?	Located where in your home?

\*Attach & date a separate page for additional medications or to record updates.

Allergies to Medications: \_\_\_\_\_  
\_\_\_\_\_

## Hospital Information

Hospital Preference: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Last Hospitalization: \_\_\_\_\_

Hospital: \_\_\_\_\_ Date: \_\_\_\_\_ Treated For: \_\_\_\_\_

Living Will If yes, location of Living Will: \_\_\_\_\_

Do Not Resuscitate (DNR) Order Location of DNR: \_\_\_\_\_

Organ Donor

## Medical Insurance Coverage

Medicare #: \_\_\_\_\_ Medicaid #: \_\_\_\_\_

Blue Cross/Blue Shield #: \_\_\_\_\_

Other Policy #: \_\_\_\_\_