

VIAL OF L.I.F.E.
Lifesaving Information for Emergencies

PATIENT INFORMATION:

Name: _____ Date of Birth: _____

Address: _____ Sex: _____

City: _____ State: _____ Zip: _____ Phone: _____

Date this form was completed: _____ Signature: _____

HEALTH INFORMATION:

Primary Medical Problems: _____

Currents medications being taken and dosages: _____

Known allergies to medications: _____

Other allergies: _____

Do you have a Pacemaker? _____ If yes, Model #: _____ Blood Type: _____

PREVIOUS MEDICAL PROBLEMS: (check all that apply)

_____ Heart	_____ Epilepsy	_____ Stroke	_____ Glaucoma	_____ Asthma
_____ Siezures	_____ Hemophilia	_____ Emphysema	_____ Diabetes	_____ Hypoglycemia
_____ Anemia	_____ AIDS	_____ Cancer	_____ Low BP	_____ High BP

MEDICAL INFORMATION:

Medical Insurance Carrier: _____ Medical Number: _____

Other Health Insurance & Number: _____ Medicare Number: _____

Primary Doctor's Name: _____ Doctor's Phone: _____

Hospital Choice: _____ Location: _____

Have you been a patient at this hospital before: _____ Date: _____

Do you have a medical directive: _____ Where is it located? _____

EMERGENCY REFERENCE CONTACTS:

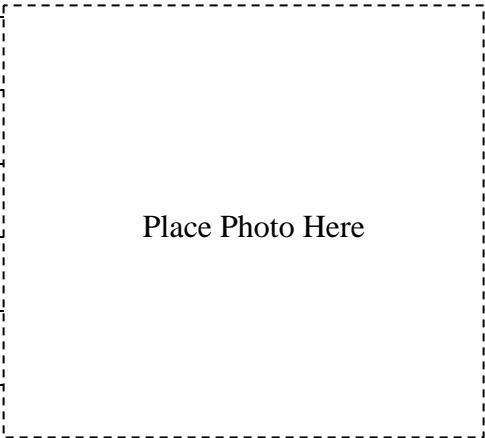
Name: _____ Phone: _____

Address: _____ Relationship: _____

Name: _____ Phone: _____

Address: _____ Relationship: _____

Please write below any comments or instructions which would be helpful to emergency responders in assisting you during a personal emergency. Some such pertinent information might be religion or religious beliefs, life support wishes, organ donation wishes, burial or cremation, etc. You might want to attach a photograph of yourself so emergency personnel can match the information provided to the correct person.



PET INFORMATION

Pet Name	Type of Animal	Color, or Notable Markings	Food Instruction(s), location of pet food onboard	Medicine, or Other Special Needs