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.

Place Photo Here

PET INFORMATION

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