VIAL OF LIFE

DATE COMPLETED:_____

EMERGENCY MEDICAL INFORMATION - FOR RESCUE SQUAD

FIRST NAME	INITIAL	LAST NAME				SOCIAL SECURITY NUMBER	
STREET		CITY		STATE	ZIP	TELEPHONE	
DATE OF BIRTH	MALE/FEMALE	HEIGHT	WEIGHT	HAIR COLOR	EYE COLOR	BLOOD TYPE	RELIGION
IF PACEMAKER, MODEL #		DEFIBRILATOR, MODEL #		HEARING AID L R	DEAF L R	DENTURES UPPER LOWER	UNABLE TO SPEAK ☐
VISION	GLASSES ☐	CONTACTS		BLIND L R	ARTIFICIAL EYE L R	NATIVE LANGUAGE IF NOT ENGLISH	

IDENTIFYING MARKS:

CIRCLE CONDITIONS YOU HAVE BEEN TREATED FOR IN THE PAST

AIDS	BLOOD PRESSURE	EPILEPSY	HEART CONDITION	TUBERCULOSIS
ANEMIA	CANCER	GLAUCOMA	JAUNDICE	OTHER:
ARTHRITIS	DIABETES	HAY FEVER	SINUS	
ASTHMA	INSULIN Y / N	HEPATITIS	STROKE	

CURRENTLY BEING TREATED FOR?

CURRENT MEDICATIONS/DOSAGE/FREQUENCY/LOCATED	CURRENT MEDICATIONS/DOSAGE/FREQUENCY/LOCATED
NAME OF DOCTOR TELEPHONE NUMBER	NAME OF DOCTOR TELEPHONE NUMBER
NAME OF DOCTOR TELEPHONE NUMBER	NAME OF DOCTOR TELEPHONE NUMBER

ALLERGIES TO MEDICATIONS

LAST HOSPITALIZATION

HOSPITAL LOCATION YEAR PATIENT #

LIVING WILL REFER TO: ☐

ORGAN DONER REFER TO: ☐

MEDICAL COVERAGE

BLUE CROSS #_____ BLUE SHIELD #_____ MEDICARE #_____

MEDICAID # OTHER POLICY #

IN CASE OF EMERGENCY - NOTIFY RELATIONSHIP

STREET ADDRESS APT CITY STATE ZIP PHONE

PLACE ON FRONT OF REFRIGERATOR AND UPDATE AS NEEDED