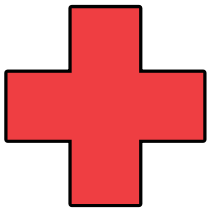
VIAL OF LIFE

EMERGENCY MEDICAL INFORMATION

Please check and update this form monthly for accuracy!



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

Covid Vaccination: Type_____ _____ Booster:_____

Dates_____

Medical History

Check Conditions that you have been treated for:

☐ Allergies	☐ Blood Pressure	☐ Epilepsy	☐ Heart Condition	☐ Anxiety
☐ Anemia	☐ Cancer	☐ Glaucoma	☐ Jaundice	
☐ Arthritis	☐ Diabetes	☐ Hay Fever	☐ Sinus	
☐ Asthma	☐ Insulin	☐ Hepatitis	☐ Stroke	

Be sure to complete reverse side →

Current Medical Information

Name of Doctor:_____ Phone #: _____

Name of Doctor:_____ Phone #: _____

Currently Being Treated For:

_____

_____

*Current Medications: **See attached pharmacy card

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 #: _____