

Vial of LIFE - Lifesaving Information For Emergencies

Use pencil to print information (it's easier to make updates & won't run if moist)
Give special attention to current medications and allergies. Keep the form updated.

Date form completed: _____ (remember to change with each update to form) Non-English Speaking

PERSONAL DATA:

Name: _____ Sex: M / F
Address: _____ Date of Birth: _____
Phone: _____ Cell Phone: _____ Height: _____ Weight: _____
Primary Physician Name: _____ Phone Number: _____
Secondary Physician Name: _____ Phone Number: _____
Hospital Preferred: _____

IN CASE OF EMERGENCY NOTIFY:

Name: _____ Relationship: _____
Address: _____
Phone: _____ Cell Phone: _____ Work Phone: _____
Name: _____ Relationship: _____
Address: _____
Phone: _____ Cell Phone: _____ Work Phone: _____

MEDICAL / INSURANCE DATA:

Primary Insurance Name: _____ Policy Number: _____
Secondary Insurance Name: _____ Policy Number: _____
Medicare Policy Number: _____
Medicaid Policy Number: _____

HEALTH INFORMATION:

Currently on Chemo Therapy? Y / N
Currently on Blood Thinners? Y / N If Yes – How Much? _____
Currently use Insulin? Y / N If Yes – How Often? _____

Allergies: (check all that exist)

NO Known Allergies Aspirin Codeine Demerol
 Insect Stings Latex Morphine Penicillin
 Sulfa Tetanus Other: _____

Medical Assist Devices: (check all that exist)

NO Medical Assist Devices
 Dentures Eye Glasses Contacts Hearing Aids
 Prosthetic Devices – Type: _____
 Medically Inserted Tubes – Type: _____
 Using Oxygen – How many liters: _____
 Pacemaker / Defibrillator – Model Number: _____

Where do you keep medications: _____

Which Pharmacy do you use: _____

List of Medications - currently taking - include dosage & frequency (ie Lasix - 20 mg 1 tablet 2X day)

MEDICAL HISTORY / CONDITIONS:

Diagnosed or Treated for (check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Angina | <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis / Fibromyalgia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bleeding / Clotting Disorder | <input type="checkbox"/> Cancer – Type: _____ |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> COPD |
| <input type="checkbox"/> Dementia / Alzheimer’s | <input type="checkbox"/> Diabetes (High Sugar) | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Edema / Swelling | <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> Eye / Vision Impairment |
| <input type="checkbox"/> Gall Bladder Disease | <input type="checkbox"/> Gastric Disease | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Hepatitis – Type: _____ | <input type="checkbox"/> Hiatal Hernia |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Hypoglycemia (Low Sugar) |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Ulcers / GERD | <input type="checkbox"/> Unable to Speak |
| <input type="checkbox"/> <u>NO</u> Medical Conditions | <input type="checkbox"/> Other (specify in space below) | |

Instructions:

1. Fill out the **Vial of LIFE** form

Answer all or any pertinent questions.

Make blank copies of this form to use later, to keep information current.

2. Place the form in the **Vial**.

Place the form you filled out in the plastic vial.

You may also consider placing the following items in the vial.

- Copy of EKG
- DNR (Do Not Resuscitate)
- Living will or equivalent
- Recent picture of self

3. Place the **Vial** in the refrigerator door

The upper right compartment of the refrigerator door (behind the “butter door”) is a safe place where the vial won’t get lost in the leftovers.

4. Place the magnet on the refrigerator door

It’s easily seen by emergency responders and they know where to look for vital data.

