Vial of LIFE – Lifesaving Information For Emergencies

www.SclhWatch.org

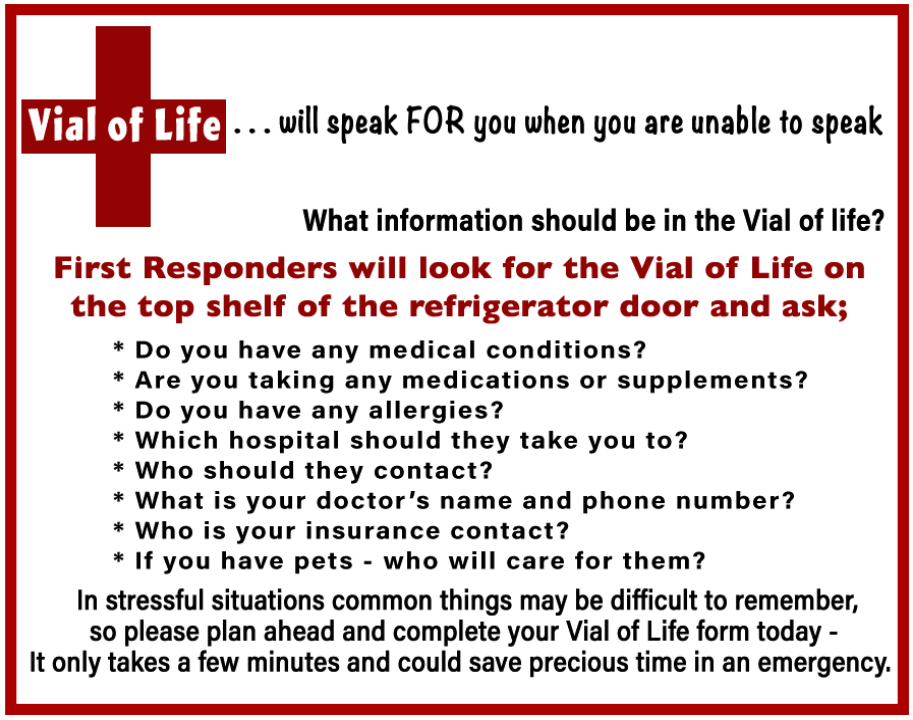
WHAT IS THE VIAL OF LIFE PROGRAM?

The Vial of Life is an Medical history Information document that provides crucial personal and medical history in case of an emergency. The documents provide paramedics and firefighters with crucial personal and medical information that will speak for you if you are unable to communicate or you do not have a representative in the event of an emergency.

HOW DO I USE THE VIAL OF LIFE?

There are five easy steps to using the Vial of Life.

1. Although the **Emergency Medical Information Form** is part of the **Neighborhood Watch Welcome Packet**, a current copy can be downloaded **HERE** – be sure to *save to your computer.*
2. Fill out the information completely; making sure it is current and legible.
3. Fold this document and the completed *Emergency Medical Information Form* and place in a plastic baggie. (If you have a "Do Not Resuscitate" (DNR) form, be sure to attach a copy.)
4. Although a Vial of Life sticker may be placed on your front door, *First Responders will automatically look in the refrigerator door for your Vial of Life information*.
5. Place the baggie containing your medical information on the top shelf of your refrigerator door.



NOTE: The Vial of Life will only work if the information is accurate, complete, and updated as changes occu

Sun City Lincoln Hills Neighborhood Watch

VIAL OF LIFE

EMERGENCY MEDICAL INFORMATION

Please check and update this form monthly for accuracy!

Date Completed: _____ Updated: _____ _____ _____ _____ _____ _____ _____

Basic Information

Name: _____ Phone: _____

Street: _____ City: _____ State: _____ Zip: _____

In an Emergency, please notify: _____ Phone: _____

Street: _____ City: _____ State: _____ Zip: _____

If pets are in the home, in an emergency notify: _____ Phone: _____

Pet names/additional information: _____

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

Medical History

Check Conditions that you have been treated for:

☐ Allergies	☐ Blood Pressure	☐ Epilepsy	☐ Heart Condition	☐ Tuberculosis
☐ 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:

Medication	Dosage	Taken How Often? (Frequency)	Taken to treat what condition?	Located where in your home?

*** FOR ADDITIONAL MEDICATIONS OR TO RECORD UPDATES, ATTACH & DATE A SEPARATE PAGE.**

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 Information

Medicare #:_____ Medicaid #: _____

Blue Cross/Blue Shield #: _____

Other Policy #: _____