

# Vial of LIFE – Lifesaving Information For Emergencies

## 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. Identify someone who can reach your home quickly, i.e. caregiver for dependent if you are hospitalized.
4. Fold the completed information form and place it in a plastic baggie. (If you have a “Do Not Resuscitate” (DNR) form, be sure to attach a copy.)
5. Although a Vial of Life sticker may be placed on your front door, medical personnel will automatically look in the refrigerator door for your Vial of Life information.
6. 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 occur.



**Vial of Life** . . . will speak FOR you when you are unable to speak

**What information should be in the Vial of life?**

**First Responders will look for the Vial of Life on the top shelf of the refrigerator door and ask;**

- \* Do you have any medical conditions?
- \* Are you taking any medications or supplements?
- \* Do you have any allergies?
- \* Which hospital should they take you to?
- \* Who should they contact?
- \* What is your doctor's name and phone number?
- \* Who is your insurance contact?
- \* If you have pets - who will care for them?

In stressful situations common things may be difficult to remember, so please plan ahead and complete your Vial of Life form today - It only takes a few minutes and could save precious time in an emergency.



# 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:

<input type="checkbox"/> Allergies	<input type="checkbox"/> Blood Pressure	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cancer	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Jaundice	<input type="checkbox"/>
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Sinus	<input type="checkbox"/>
<input type="checkbox"/> Asthma	<input type="checkbox"/> Insulin	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Stroke	<input type="checkbox"/>

**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 #: \_\_\_\_\_