VIAL OF LIFE

Date Completed _____

EMERGENCY MEDICAL INFORMATION - FOR RESCUE SQUAD

Keep this form updated!

Personal Information

Name:_____Gender: M F Date of Birth:_____Soc. Sec. #_____

Address: _____Phone: _____

Contact Person:_____Relationship:_____Phone:_____

Insurance coverage: Company_____Policy #_____

Doctor(s):

Primary:_____Phone:_____

Specialist:_____Specialty:_____Phone:_____

Check Condition(s) You Have Been Treated for in the Past:

☐ AIDS/HIV ☐ Anemia ☐ Arthritis ☐ Asthma ☐ Blood pressure ☐ Cancer

☐ CVA/Stroke ☐ Diabetes ☐ Epilepsy ☐ Glaucoma ☐ Heart Condition ☐ Hepatitis

☐ Jaundice ☐ Pacemaker ☐ Tuberculosis

☐ Other: _____

Allergic to:

Environmental (e.g. dust, food, latex):_____

Medicines:_____

Currently being treated for: _____

Current Medication	Dosage	Frequency