Date Completed: ______________

VIAL OF LIFE

MEDICAL INFORMATION FORM: This form should be readily available for responding fire crews.

NAME:______________________________ Phone #______________________

ADDRESS:____

DATE OF BIRTH:____________________ AGE:__________

EMERGENCY CONTACT NAME__________________ EMERGENCY CONTACT #:________

PRIMARY DOCTOR NAME:__________________ DOCTORS PHONE #__________________

CURRENT MEDICAL HISTORY: ____

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CURRENT MEDICAL CONDITIONS:

( ) AIDS/HIV	( ) Diabetes	( )High Blood Pressure
( ) Anemia	( ) Dementia	( ) Internal Defibrillator
( ) Asthma	( ) Emphysema	( ) Low Blood Pressure
( ) Angina	( ) Epilepsy	( ) Pacemaker
( ) Breathing Problems	( ) Glaucoma	( ) Seizures
( ) Cancer	( ) Heart Condition	( ) Stroke
( ) COPD	( ) Hearing Problems	( ) Tuberculosis
( ) Other	( ) Hepatitis	

CURRENT MEDICATIONS AND DOSAGES:

MEDICATION	DOSAGE	LOCATION

ALLERGIES:

ANY ADDITIONAL INFORMATION:

I certify that the information on these forms is accurate and up-to-date. I authorize medical care for myself and my family in the event of illness or injury.

Signature: ______________________ Print Name:______________________________