VIAL OF LIFE

LIVEWELLSD.ORG

Information & Assistance
1-800-339-4661
Updated On
___/___/___

Name ____________________

☐ Blind ☐ Deaf ☐ Alzheimer's Disease or Related Dementia

Address __________ City __________ Zip ______

Phone # __________ Male ☐ Female ☐ Date of Birth ______

Social Security Number (last four digits) __________

Medicare Number (last four digits) __________

Other Insurance __________ Policy Number __________

Do you have an Advance Health Care Directive? Yes ☐ No ☐

If yes, location __________ Agent __________ Phone # __________

Do you have a "Do Not Resuscitate Order" Yes ☐ No ☐

Registered with Sheriff's "Take Me Home"? Yes ☐ No ☐

Emergency Contacts

Name __________ Relationship __________ Phone # and E-mail __________

Name __________ Relationship __________ Phone # and E-mail __________

Caregiver __________ Phone # and E-mail __________

Clergy __________ Phone # and E-mail __________

Pet's Information Name & Type __________

Veterinarian __________ Phone # __________

Medical Information

Primary Doctor __________ Phone # __________

Secondary Doctor __________ Phone # __________

Hospital __________ Phone # __________

Height __________ Weight __________ Blood Type __________

Normal Bood Pressure __________

Allergies to drugs or foods __________

Please list any medical conditions that apply (for example: cardiac, diabetes, hypertension, stroke) __________

Surgeries (type and date)

Do you?

Wear dentures? Yes ☐ No ☐

Wear contacts? Yes ☐ No ☐

Wear hearing aids? Yes ☐ No ☐

Wear glasses? Yes ☐ No ☐

Use Oxygen? Yes ☐ No ☐

Wheelchair? Yes ☐ No ☐

Other Important Emergency Information

Immunizations

Where do you keep your medications?

Medications
(Prescription, Over-the-counter Drugs, Vitamins, Herbal Supplelments)

Name	Dose-Frequency	Purpose
Name	Dose-Frequency	Purpose
Name	Dose-Frequency	Purpose
Name	Dose-Frequency	Purpose
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Please record all information in a manner easy to read by emergency medical personnel.