VIAL OF L.I.F.E.

Lifesaving Information For Emergencies

Milpitas Fire Dept.

I certify that the information on this form is accurate and up-to-date. I also understand that emergency medical personnel may rely upon this information and agree to hold the user harmless.

DATE COMPLETED: _____ **SIGNATURE:** _____

PATIENT INFORMATION:

Name:		Date of Birth:
Address:		Sex: Male Female
City:	State:	Zip Code:
Social Security No.:		Phone: ( )

Primary Medical Problems:			
Doctor's Name:		Doctor's Phone:	
Hospital Preference:		Have you been a patient there: Yes	No
Medicare #:		Medical #:	
Other Health Insurance:		Health Insurance #:	

HEALTH INFORMATION:

Allergies to medication:				
Other allergies:				
Current Medications: Name/Dose				
Do you have a pacemaker?	Yes	No	Model #:	Blood type:
Do you have a directive?	Yes	No	Where is it?	

PREVIOUS MEDICAL PROBLEMS: *(Check all that apply)*

☐ Heart	☐ Epilepsy	☐ Stroke	☐ Glaucoma
☐ Asthma	☐ Hemophilia	☐ Diabetes	☐ Hypoglycemia
☐ Seizures	☐ Emphysema	☐ AIDS	☐ Anemia
☐ Cancer	☐ Low Blood Pressure	☐ High Blood Pressure	

☐ Others: _____

EMERGENCY REFERENCES:

Name:	Phone:
Address:	Relation:
Name:	Phone:
Address:	Relation:

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Please write below any comments or instructions, which would be helpful to emergency responders in assisting you during a personal emergency. Consider attaching a photograph of yourself to ensure proper identification.

ADDITIONAL INFORMATION: