VIAL OF LIFE
Medical Info Form

DATE COMPLETED

FIRST NAME	INITIAL	LAST NAME	SSN

STREET	CITY	STATE	ZIP	PHONE

DOB	M / F	HT	WT	HAIR COLOR	EYE COLOR	BLOOD TYPE	RELIGION

LIST HEARING DIFFICULTIES	DENTURES UPPER / LOWER	UNABLE TO SPEAK ❑

LIST VISION DIFFICULTIES	PRIMARY LANGUAGE (IF NOT ENGLISH)

IDENTIFYING MARKS

CURRENT MEDICAL CONDITIONS

PAST MEDICAL CONDITIONS

CURRENT MEDICATIONS: DOSAGE & FREQUENCY

ALLERGIES TO MEDICATIONS

DOCTOR'S NAME & PHONE

LAST HOSPITALIZATION

SPECIAL INSTRUCTIONS (SUCH AS HEALTH DIRECTIVES, ETC.)

HEALTH INSURANCE POLICY

EMERGENCY CONTACT – NAME, ADDRESS, PHONE & RELATIONSHIP