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 glasses?	Yes ☐	No ☐
Wear contacts?	Yes ☐	No ☐	Use Oxygen?	Yes ☐	No ☐
Wear hearing aids?	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
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.