VIAL OF LIFE

Medical Information Form

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DATE COMPLETED:

FIRST NAME	INITIAL	LAST NAME	SSN
STREET	CITY	STATE ZIP	TELEPHONE

DOB	MALE/FEMALE	HEIGHT	WEIGHT	HAIR COLOR	EYE COLOR	BLOOD TYPE	RELIGION

List Hearing Difficulties

List Vision Difficulties

DENTURES UPPER LOWER

UNABLE TO SPEAK ☐

PRIMARY LANGUAGE (IF NOT ENGLISH)

Identifying Marks

Current Medical Conditions

Past Medical Conditions

Current Medications: Dosage & Frequency

Allergies to Medications

Doctor's Name & Phone Number

Last Hospitalization

Special Instructions (Such as Health Directives, Etc..)

Health Insurance Policy

Emergency Contact - Name, Address, Phone Number, & Relationship

PRINT CLEARLY • FOLLOW DIRECTIONS ON BACK TO STORE ON REFRIGERATOR