VIALOFLIFE

DATE COMPLETED __________

EMERGENCY MEDICAL INFORMATION - RESCUE SQUAD

FIRST NAME			INITIAL			LAST NAME		
STREET			CITY		STATE	ZIP	TELEPHONE	
DATE OF BIRTH	MALE – FEMALE	HEIGHT	WEIGHT	HAIR COLOR	EYE COLOR		BLOOD TYPE	RELIGION
PACEMAKER MODEL #		DEFIBRILLATOR MODEL #		HEARING AID RIGHT LEFT	DEAF R L	DENTURES UPPER LOWER	UNABLE TO SPEAK	
VISION	GLASSES	CONTACTS		BLIND	ARTIFICIAL EYE		NATIVE LANGUAGE IF NOT ENGLISH	
IDENTIFYING MARKS:								

MEDICAL CONDITIONS: Check all that apply.

	AIDS		Hepatitis
	Allergies		High Blood Pressure
	Anemia		Hypoglycemia
	Arthritis		Insulin: Yes No
	Asthma		Low Blood Pressure
	Cancer		Pacemaker
	Diabetes		Stroke
	Emphysema		Tuberculosis
	Glaucoma		Ulcers
	Heart Disease		Other:
	Hemophilia		Other:

Allergies to Medications:

Emergency Contact Name: Emergency Contact Phone:

Physician Name: Physician Phone:

Health Insurance: Policy#

Medicare: YES NO Medicaid: YES NO

Medical Information

Do you have an active Do Not Resuscitate (DNR)? (if yes, please attach) YES NO

Do you have an Advanced Health Directive? YES NO

Are you an organ donor? YES NO

PLACE ON THE FRONT OF REFRIGERATOR AND UPDATE AS NEEDED

(Medications listed on other side)