

American Medical Alarms sponsors the Vial of Life Program.

Please cut out the two Vial of Life pictures below. Fill out the Vial of Life form and put it behind one cut out in a plastic bag and tape the bag to the front of your refrigerator. Then put the second cut out in a bag and tape it on the outside of your front door. Be sure to amend the information on your Vial of Life form as your medications and or medical information changes. You can print new forms anytime you need them by visiting our website:

[www.americanmedicalalarms.com](http://www.americanmedicalalarms.com)



Thank you!

American Medical Alarms

# VIAL OF LIFE

DATE COMPLETED: \_\_\_\_\_

## EMERGENCY MEDICAL INFORMATION - FOR RESCUE SQUAD

**Sponsored by American Medical Alarms, Inc. - Phone Toll Free (800) 542-0438**

FIRST NAME			INITIAL	LAST NAME			SOCIAL SECURITY NUMBER			
STREET			CITY		STATE	ZIP	TELEPHONE			
DATE OF BIRTH		MALE/FEMALE	HEIGHT	WEIGHT	HAIR COLOR	EYE COLOR		BLOOD TYPE	RELIGION	
IF PACEMAKER, MODEL #			DEFIBRILATOR, MODEL #			HEARING AID	DEAF		DENTURES	UNABLE TO SPEAK
VISION		GLASSES	CONTACTS		BLIND	ARTIFICIAL EYE		UPPER LOWER	NATIVE LANGUAGE IF NOT ENGLISH	
		<input type="checkbox"/>			L	R	L	R	<input type="checkbox"/>	
		<input type="checkbox"/>			L	R	L	R		
IDENTIFYING MARKS:										
CIRCLE CONDITIONS YOU HAVE BEEN TREATED FOR IN THE PAST										
AIDS		BLOOD PRESSURE		EPILEPSY		HEART CONDITION		TUBERCULOSIS		
ANEMIA		CANCER		GLAUCOMA		JAUNDICE		OTHER:		
ARTHRITIS		DIABETES		HAY FEVER		SINUS				
ASTHMA		INSULIN Y / N		HEPATITIS		STROKE				
CURRENTLY BEING TREATED FOR?										
CURRENT MEDICATIONS/DOSAGE/FREQUENCY/LOCATED					CURRENT MEDICATIONS/DOSAGE/FREQUENCY/LOCATED					
NAME OF DOCTOR			TELEPHONE NUMBER		NAME OF DOCTOR			TELEPHONE NUMBER		
NAME OF DOCTOR			TELEPHONE NUMBER		NAME OF DOCTOR			TELEPHONE NUMBER		
<b>ALLERGIES TO MEDICATIONS</b>										
<b>LAST HOSPITALIZATION</b>										
HOSPITAL		LOCATION			YEAR		PATIENT #			
LIVING WILL		<input type="checkbox"/>	ORGAN DONOR				<input type="checkbox"/>			
REFER TO:					REFER TO:					
<b>MEDICAL COVERAGE</b>										
BLUE CROSS # _____			BLUE SHIELD # _____			MEDICARE # _____				
MEDICAID # _____			OTHER _____			POLICY # _____				
IN CASE OF EMERGENCY - NOTIFY					RELATIONSHIP					
STREET ADDRESS			APT	CITY	STATE	ZIP	PHONE			

**PLACE ON FRONT OF REFRIGERATOR AND UPDATE AS NEEDED**