



Vial Of L.I.F.E.

Lifesaving Information For Emergencies



Gilroy Firefighters
Local 2805

I certify that the information on this form is accurate and up-to-date. I also understand that emergency medical personnel may rely upon this information and agree to hold the user harmless.

Date Completed: _____ Signature: _____

PATIENT INFORMATION:

Name:	Date of Birth:	
Address:	Sex: Male Female	
City:	State:	Zip Code:
Social Security No.:	Phone: ()	
Primary Language:		

Primary Medical Problems:	
Doctor's Name:	Doctor's Phone:
Hospital Preference:	Have you been a patient there: Yes No
Medicare #:	Medical #:
Other Health Insurance:	Health Insurance #:

HEALTH INFORMATION:

Allergies to medication:
Other allergies:
Current Medications: Name/Dose
Do you have a pacemaker? Yes No Model #: Blood type:
Do you have a DO NOT RESUSCITATE FORM? Yes No Where is it? It is a good idea to keep the original or a copy of this form in your Vial of L.I.F.E. kit. To be valid, this DNR Form must be approved by the EMSA , as well as the CMA and bearing the insignias of both organizations. It must be signed by you and your doctor.

PREVIOUS MEDICAL PROBLEMS: (Check all that apply)

- AIDS
- Anemia
- Asthma
- Cancer
- Diabetes
- Emphysema
- Epilepsy
- Glaucoma
- Heart
- Hemophilia
- High Blood Pressure
- Hypoglycemia
- Low Blood Pressure
- Seizures
- Stroke
- Others:

