

VIAL OF LIFE VIAL OF LIFE

www.palmbayflorida.org

The **VIAL OF LIFE** program is designed to provide Emergency Response Personnel with life and time saving medical information in the home and automobile.

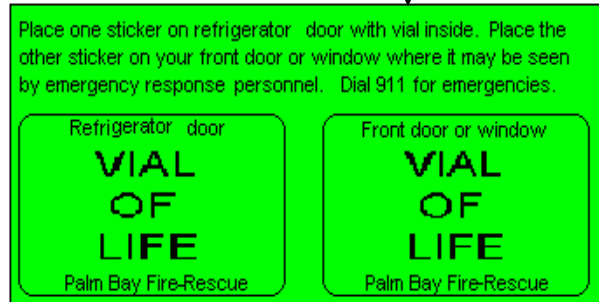
For more information, or to receive additional kits, please contact:
PALM BAY FIRE-RESCUE
(321) 409-6300

INSTRUCTIONS:

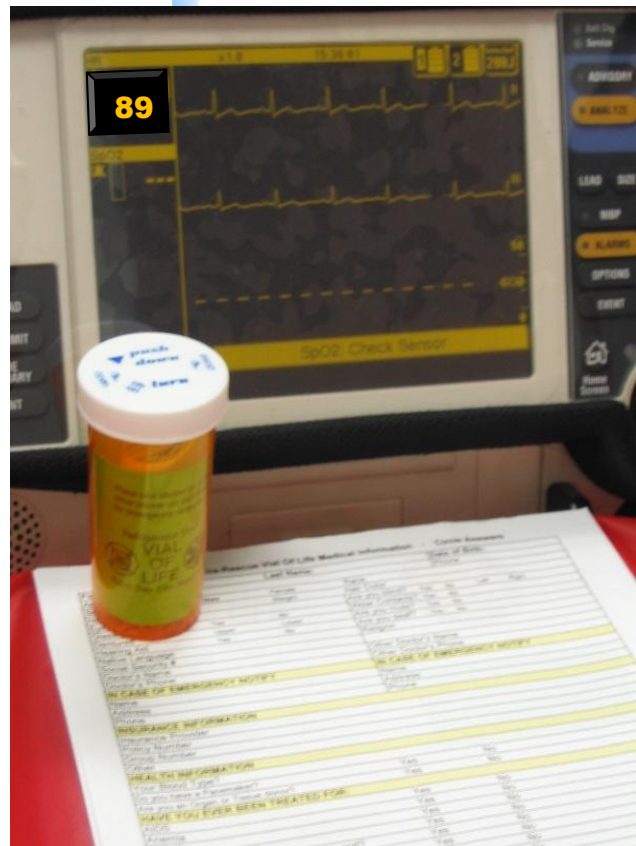
- Print all information in pencil to allow for periodic updating.
- Give special attention to current medications and allergies to medications.
- Update this form each time medications or general information changes.
- Fold the form and insert it into the vial.
- Keep the vial on the upper shelf or in a conspicuous location in your refrigerator.
- Place one of the enclosed stickers on the refrigerator door and the other sticker on your front door or window where it can be seen by emergency responders.
- In the automobile, place the vial inside the glove-compartment box.
- Use one of the stickers on the outside or the glove-box and the other on the backside of the rear view mirror.



Follow instructions on sticker ↓



**Update Your Vial of Life at Least
Every 6 Months**



Palm Bay Fire-Rescue Vial Of Life Medical Information - Circle Answers

First Name:		Last Name:		Date of Birth:			
Address				Phone			
Sex	Male	Female	Race				
Height	Weight		Hair Color				
Eye Color			Are you blind?	Yes	No	Left	Right
Glasses	Yes	No	Wear Contacts?	Yes	No		
Dentures	Upper	Lower	Are you mute?	Yes	No		
Hearing Aid	Yes	No	Are you deaf?	Yes	No		
Native Language			Religion				
Social Security #							
Doctor's Name			Other Doctor's Name				
Doctor's Phone			Other Doctor's Phone				
IN CASE OF EMERGENCY NOTIFY				IN CASE OF EMERGENCY NOTIFY			
Name				Name			
Address				Address			
Phone				Phone			
INSURANCE INFORMATION							
Insurance Provider							
Policy Number							
Group Number							
Other							
HEALTH INFORMATION							
Your Blood Type?							
Do you have a Pacemaker?		Yes	No				
Are you an Organ or Tissue donor?		Yes	No				
HAVE YOU EVER BEEN TREATED FOR:							
AIDS		Yes	No				
Anemia		Yes	No				
Arthritis		Yes	No				
Cancer		Yes	No				
On chemo-therapy? Or have chem port?		Yes	No				
Dialysis		Yes	No				
Diabetes		Yes	No				
Epilepsy		Yes	No				
Glaucoma		Yes	No				
Heart Condition		Yes	No				
Hepatitis		Yes	No				
High Blood Pressure		Yes	No				
Respiratory		Yes	No				
Sickle Cell		Yes	No				
Stroke		Yes	No				
Tuberculosis		Yes	No				
Other (Specify)							
CURRENT MEDICATIONS LIST				DOSAGE AMOUNT		Do you have any ALLERGIES to medications? Please List.	
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							