

VIAL OF LIFE

Life-saving Information @ www.cincinnatiaredcross.org/vialoflife

The Vial of Life has been designed to keep important medical information about you. It is to be used by medical personnel in case of an emergency.

- Please update the information as needed. This information should remain rolled up in the vial so that it will be easily accessible.
- Update your information by downloading this form from www.cincinnatiaredcross.org/vialoflife
- The Vial of Life is to be placed on the front, upper right-hand shelf of your refrigerator.
- Place the Vial of Life magnet on the refrigerator so that emergency personnel will notice it.
- **Please fill out both sides of the Vial of Life form.**

This Vial of Life has been given to you by:

PEPSI AMERICAS



Cincinnati Area Chapter
Disaster Preparedness
720 Sycamore Street
Cincinnati, Ohio 45202-2115

Private Insurance _____
Medicare # _____
Medicaid _____
Hospital Preference _____
Signed Living Will Yes No
Location _____
Date of last tetanus shot _____
Special diet _____
Language Spoken _____
Religion _____
Next of kin, contact:
Name _____
Address _____
Day Phone _____
Evening Phone _____
In case of emergency, contact:
Name _____
Address _____
Day Phone _____
Evening Phone _____

Keep Information Up to Date! Review at least every six months. Medical Data Reviewed as of Mo ___ Yr ___

Please Print

Name _____ Sex M F
 Address _____
 Phone _____
 Date of Birth _____ SS# _____
 Blood Type _____ Religion _____
 Living Will on file at _____
 Doctor _____ Phone _____
 Doctor _____ Phone _____

History

Heart Disease Hypertension
 Respiratory Stroke/TIA
 Seizures Diabetes
 Cancer Psychological
 Contacts Glasses Dentures
 Other _____

Recent Surgery _____ Date _____

Do you have an EMS-NO CPR or a DNR Form?

Yes No

Where is it located? _____

High Blood Pressure Yes No

Normal Reading _____ Date _____

Medical Conditions

(Check all that exist)

No known medical conditions Hemodialysis
 Abnormal EKG Hemolytic Anemia
 Adrenal Insufficiency Hypertension
 Angina Hypoglycemia
 Asthma Laryngectomy
 Bleeding Disorder Leukemia
 Cardiac Dysrhythmia Lymphomas
 Cataracts Memory Impaired
 Clotting Disorder Myasthenia Gravis
 Coronary Bypass Graft Pacemaker
 Dementia Alzheimer's
 Heart Valve Prosthesis Renal Failure
 Diabetes/Insulin Dependent Seizure Disorder
 Eye Surgery Sickle Cell Anemia
 Glaucoma Stroke
 Hearing Impaired Vision Impaired
 Other _____

Allergies

No Known Allergies
 Latex Horse Serum Sulfa
 Aspirin Insect Stings Tetracycline
 Barbiturate Lidocaine X-ray Dyes
 Codeine Morphine Demerol
 Novocaine Adhesive Tape Environmental
 Other _____

Medical Problems	Medication	Dosage	Frequency

Where I keep my medications _____