# VIAL OF LIFE

Life–saving Information @ www.cincinnatiredcross.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.cincinnatiredcross.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

American Red Cross

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 ( ) Myasthenla 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 _____