VIAL OF L.I.F.E.

Lifesaving **I**nformation **F**or **E**mergencies

PATIENT INFORMATION:

Name:		Date of Birth:	
Address:		Gender	☐ Male ☐ Female
City:	State:	Zip Code:	
Social Security No.:		Phone: ( )	

Primary medical problems:			
Doctors name:		Doctors phone:	
Hospital preference:		Have you been a patient there?	☐ Yes ☐ No
Medicare #:	Other health insurance:	Policy #	

HEALTH INFORMATION

Current medications / Dose
(If you need to list others, please attach list to this form)

Medical Problems:

☐ Heart	☐ Diabetes	☐ AIDS
☐ Asthma	☐ AIDS	☐ Anemia
☐ Seizures	☐ Pacemaker	☐ Glaucoma
☐ Cancer	☐ Hypoglycemia	☐ Epilepsy
☐ Hemophilia	☐ Emphysema	☐ Stroke

☐ High Blood Pressure ☐ Low Blood Pressure

☐ Other (list)

Allergies to Medication:			
Do you have an Advanced Directive or DNR?	☐ Yes	☐ No	Where is it?

EMERGENCY CONTACTS:

Name	Relationship:	Phone:
Name	Relationship:	Phone:

I certify that the information on this form is accurate and up-to-date. I also understand that emergency personnel may rely on this information and I agree not to hold emergency personnel responsible for inaccurate or out of date information.

SIGNATURE (REQUIRED) _____ **DATE COMPLETED** _____

PLEASE ATTACH A RECENT PHOTOGRAPH AND LIST OF ANY OTHER INFORMATION TO THIS FORM
Additional forms may be obtained from your physician, fire station or downloaded at www.marincountyfire.org

Marin General Hospital
Novato Community Hospital
Sutter Health Affiliates
With You. For Life.

COUNTY OF MARIN

KAISER PERMANENTE

MARIN COUNTY FIRE CHIEFS

AMR AMERICAN MEDICAL RESPONSE

NORCAL AMBULANCE

ST JOSEPH'S AMBULANCE SERVICE