American Medical Alarms sponsors the Vial of Life Program.

Please cut out the two Vial of Life pictures below. Fill out the Vial of Life form and put it behind one cut out in a plastic bag and tape the bag to the front of your refrigerator. Then put the second cut out in a bag and tape it on the outside of your front door. Be sure to amend the information on your Vial of Life form as your medications and or medical information changes. You can print new forms anytime you need them by visiting our website: www.americanmedicalalarms.com

Thank you!

American Medical Alarms

VIAL OF LIFE

DATE COMPLETED:_____

EMERGENCY MEDICAL INFORMATION - FOR RESCUE SQUAD

Sponsored by American Medical Alarms, Inc. - Phone Toll Free (800) 542-0438

FIRST NAME	INITIAL	LAST NAME			SOCIAL SECURITY NUMBER	
STREET	CITY	STATE	ZIP	TELEPHONE		
DATE OF BIRTH	MALE/FEMALE	HEIGHT	WEIGHT	HAIR COLOR	EYE COLOR	BLOOD TYPE	RELIGION
IF PACEMAKER, MODEL #	DEFIBRILATOR, MODEL #	HEARING AID L R	DEAF L R	DENTURES UPPER LOWER	UNABLE TO SPEAK ☐		
VISION	GLASSES ☐	CONTACTS	BLIND L R	ARTIFICIAL EYE L R	NATIVE LANGUAGE IF NOT ENGLISH		

IDENTIFYING MARKS:

CIRCLE CONDITIONS YOU HAVE BEEN TREATED FOR IN THE PAST

AIDS	BLOOD PRESSURE	EPILEPSY	HEART CONDITION	TUBERCULOSIS
ANEMIA	CANCER	GLAUCOMA	JAUNDICE	OTHER:
ARTHRITIS	DIABETES	HAY FEVER	SINUS	
ASTHMA	INSULIN Y / N	HEPATITIS	STROKE	

CURRENTLY BEING TREATED FOR?

CURRENT MEDICATIONS/DOSAGE/FREQUENCY/LOCATED	CURRENT MEDICATIONS/DOSAGE/FREQUENCY/LOCATED

NAME OF DOCTOR	TELEPHONE NUMBER	NAME OF DOCTOR	TELEPHONE NUMBER
NAME OF DOCTOR	TELEPHONE NUMBER	NAME OF DOCTOR	TELEPHONE NUMBER

ALLERGIES TO MEDICATIONS

LAST HOSPITALIZATION

HOSPITAL	LOCATION	YEAR	PATIENT #

LIVING WILL ☐ ORGAN DONER ☐

REFER TO: REFER TO:

MEDICAL COVERAGE

BLUE CROSS #_____ BLUE SHIELD #_____ MEDICARE #_____

MEDICAID # OTHER POLICY #

IN CASE OF EMERGENCY - NOTIFY RELATIONSHIP

STREET ADDRESS	APT	CITY	STATE	ZIP	PHONE

PLACE ON FRONT OF REFRIGERATOR AND UPDATE AS NEEDED