

For Emergencies DIAL: 911



Vial of L.I.F.E.

(Lifesaving Information For Emergencies)

I certify that the information on this form is accurate and up-to-date. I also understand that emergency medical personnel may rely upon this information and agree to hold the user harmless.

PATIENT INFORMATION: Name:	Date Completed:		Signature:		
Address: City: State: Zip Code: Social Security Number: Phone #:	PATIENT INFOR	MATION:			
City: State: Zip Code: Social Security Number: Phone #:	Name:			Date of Birth:	
City: State: Zip Code: Social Security Number: Phone #: - Primary Language: Physician's Phone #: - Primary Physician: Physician's Phone #: - Hospital Preference: Have you ever been a patient there? Yes Medical Insurance Provider: Insurer's Phone #: - Insurance ID #: Insurance Group #: Medicaid #: - Other Medical Insurance: Other Insurance Phone #: - - Other Insurance Group #: HEALTH INFORMATION: Current and Previous Medical Conditions: (Check all that apply) High Blood Pressure Alzheimers Angina Seizures Hepatitis B Diabetes Diabetes Cancer COPD AIDS/HIV Sickle Cell Hepatitis C Emphysema Heart Dementia Asthma Stroke Blood Type: Allergies to Medication: COHOR Allergies to Medication: COHOR Allergies COHOR	Address:			Sex: Male Female	
Primary Language: Primary Physician: Physician's Phone #: Have you ever been a patient there? Yes Medical Insurance Provider: Insurance ID #: Medicare #: Other Medical Insurance: Other Insurance Phone #: Other Insurance Group #: HEALTH INFORMATION: Current and Previous Medical Conditions: (Check all that apply) Alzheimers Angina Seizures Hepatitis B Diabetes Cancer COPD AIDS/HIV Sickle Cell Hepatitis C Emphysema Heart Dementia Asthma Stroke Other Allergies to Medication: Other Allergies:	City:		State:		Zip Code:
Primary Language: Primary Physician: Physician's Phone #: Have you ever been a patient there? Yes Medical Insurance Provider: Insurance ID #: Medicare #: Other Medical Insurance: Other Insurance Phone #: Other Insurance Phone #: HEALTH INFORMATION: Current and Previous Medical Conditions: (Check all that apply) Alzheimers Angina Seizures Hepatitis B Diabetes Cancer COPD AIDS/HIV Sickle Cell Hepatitis C Emphysema Heart Dementia Asthma Stroke Other Allergies to Medication: Other Allergies:				hone #:	<u>-</u>
Primary Physician: Physician's Phone #:					
Have you ever been a patient there? Yes Medical Insurance Provider:				Physician's	s Phone #:
Medical Insurance Provider: Insurance ID #: Insurance Group #: Medicare #: Other Medical Insurance: Other Insurance Phone #: Other Insurance Phone #: Other Insurance Phone #: HEALTH INFORMATION: Current and Previous Medical Conditions: (Check all that apply) Alzheimers Angina Seizures Hepatitis B Diabetes Cancer COPD AIDS/HIV Sickle Cell Hepatitis C Emphysema Heart Dementia Asthma Stroke Others: Blood Type: Allergies to Medication: Other Allergies:		.		Have vev even b	
Insurance ID #: Insurance Group #:	Medical Insurance F				
Medicare #: Medicaid #: Other Insurance Phone #:	Insurance ID #:		Insurance Gr	aun #.	
Other Insurance Phone #: Other Insurance Phone #: Other Insurance ID#: _ Other Insurance Group #:	Medicare #:			·	
Other Insurance ID#: HEALTH INFORMATION: Current and Previous Medical Conditions: (Check all that apply) High Blood Pressure Alzheimers Angina Seizures Hepatitis B Diabetes Cancer COPD AIDS/HIV Sickle Cell Hepatitis C Emphysema Heart Dementia Asthma Stroke Others: Allergies to Medication: Other Allergies:		anco.		Other Insurance	
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Alzheimers Angina Seizures Hepatitis B Diabetes Cancer COPD AIDS/HIV Sickle Cell Hepatitis C Emphysema Heart Dementia Asthma Stroke Dementia Blood Type: Allergies to Medication: Other Allergies:	HEALTH INFORM				
Cancer COPD AIDS/HIV Sickle Cell Hepatitis C Emphysema Heart Dementia Asthma Stroke Others: Blood Type: Other Allergies:	Current and Previou	ıs Medical Condit	tions: (Check all the	at apply)	High Blood Pressure
Emphysema	Alzheimers	Angina 🗌	Seizures	Hepatitis B	Diabetes
Others: Blood Type: Other Allergies:	Cancer	COPD	AIDS/HIV	Sickle Cell	Hepatitis C
Allergies to Medication: Other Allergies:	Emphysema	Heart	Dementia	Asthma	Stroke
Other Allergies:	Others:				Blood Type:
-	Allergies to Medicat	tion:			
Current Medications: (Name/Dosage)	Other Allergies:				
	Current Medications	s: (Name/Dosage))		

The Vial of L.I.F.E. is **L**ifesaving **I**nformation **F**or **E**mergencies. The Vial of L.I.F.E. kit enables emergency medical personnel to quickly locate helpful information regarding your medical history in a time of crisis. It is very important that you keep this information up to date, accurate, and placed in a prominent spot in your refrigerator.

How to use the Vial of L.I.F.E.

- Please complete a Vial of L.I.F.E. form. Be sure to include the date that you completed this form.
- Attach a photograph of yourself to the back page of the form.
- Fold the Vial of L.I.F.E. form and put it inside the Vial of L.I.F.E. container.
- Enclose any Advance Directive (Do Not Resuscitate Orders, Living Will, etc) that you wish to be followed in with the Vial of L.I.F.E.

The Vial of L.I.F.E. Kit is available free as a public service from The Rancho Santa Fe Fire Protection District. You may obtain the Vial of L.I.F.E. by picking up a kit at any Rancho Santa Fe Fire Station or administrative office. The form can be found online @ www.rsf-fire.org.

EMERGENCY CONTACTS:

Name:	Relation:	
Address:	Phone #:	
Name:	Relation:	
Address:	Phone #:	

In the blank space below please write below any comments or instructions that would be helpful to Emergency Responders in assisting you during a personal emergency. Consider attaching a current photograph of yourself to ensure proper identification.

ADDITIONAL INFORMATION: