Irving Fire Department
(972) 721-2651

VIAL OF L.I.F.E.

Life Saving Information For Emergencies

IRVING TEXAS

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personnel may rely on this information and I agree not to hold emergency personnel responsible for inaccurate or out of date information.

DATE COMPLETED:_____ **SIGNATURE**:_____

PATIENT INFORMATION:

Name:		Date of Birth:	
Address:		Sex: Male	Female
City:	State:	Zip Code:	
Social Security No.:		Phone: ( )	
Do you have a DNR directive? Yes No Where is it?			

CURRENT MEDICAL PROBLEMS:
(Check all that apply)

- ☐ Asthma
- ☐ Cardiac (Heart)
- ☐ CHF (Congestive Heart Failure)
- ☐ COPD
- ☐ Cancer (where?) _____
- ☐ Diabetes
- ☐ Emphysema
- ☐ Heart Attack (when?) _____
- ☐ Hemophilia
- ☐ High Blood Pressure
- ☐ Glaucoma
- ☐ Seizures
- ☐ Stroke (when?) _____
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____
- ☐ Contagious Disease
  - ☐ Hepatitis
  - ☐ HIV/AIDS
  - ☐ Tuberculosis
  - ☐ Other _____

ALLERGIES TO MEDICATION:
(Check all that apply)

- ☐ Penicillin
- ☐ Sulfa
- ☐ Aspirin
- ☐ Codeine
- ☐ Morphine
- ☐ Novocain
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

Do you have a pacemaker? Yes No

Do you have a defibrillator? Yes No

CURRENT MEDICATIONS:

Medication	Dose	Times/Day	Medication	Dose	Times/Day
1)			7)		
2)			8)		
3)			9)		
4)			10)		
5)			11)		
6)			12)		

EMERGENCY CONTACTS:

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

PRIMARY MEDICAL INFORMATION:

Doctor's Name:	Doctor's Phone:
Cardiologist/Specialist:	Specialist's Phone:
Hospital Preference:	Have you been a patient there? Yes No
Medicare #:	Medicaid #:
Other Health Insurance:	Health Insurance #:

Please write below any comments or instructions, which would be helpful to emergency responders in assisting you during a personal emergency.