VIAL OF LIFE
EMERGENCY INFORMATION

DIAL 911

Once completed, this Vial of Life form could save your life. It will provide emergency medical technicians with vital information about you, aiding their quick response to your emergency situation.

Instructions:

- Complete this **entire** form.
- Make 4 copies of it.
- Fold one copy, put it in a plastic bag and place bag in the top shelf of your refrigerator door (or other visible area on your refrigerator).
- Place another copy in your wallet or purse. Emergency personnel are trained to check these areas for your vital information.
- Give a copy to the two contact people you have listed on this form.

This form should be updated annually. New forms or additional copies are available at the Hampstead Fire Station or on the Fire Department web page at **www.hampsteadnh.us**.

Thank you for helping us better serve you in the case of an emergency.

Today's Date: _____

Name: _____ Date of Birth: _____ Age: _____

Street: _____ Town: _____ State: _____ Phone #: _____

Religion: _____ Pastor: _____ Phone #: _____

Insurance(s): _____

Hospital preference: _____

Primary Physician: _____ Phone #: _____

Other Physician/Specialist: _____ Phone #: _____

Pharmacy Name: _____ Phone #: _____

IN CASE OF EMERGENCY, NOTIFY: (This should be a member of your family who would be most able to quickly and capably assist you. Please also provide a second contact in case we can't reach the first)

Name:		Name:	
Relationship:		Relationship:	
Address:		Address:	
Town/State/Zip:		Town/State/Zip:	
Home Phone #:		Home Phone #:	
Work Phone #		Work Phone #:	
Cell Phone #:		Cell Phone #:	

- Continued on Reverse Side -

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Known Medical Conditions:_____

_____

Known Allergies:_____

_____

Please list all the medications you currently take:

MEDICATION	**STRENGTH**	**DOSAGE**
Example: Coumadin	***.5 mg.***	***1 capsule every morning***
1.		
2.		
3.		
4.		
5.		
6.		

I currently receive services from: (please check all applicable and provide phone numbers)

	Organization	*Phone Number*	*Special Information/Person to Contact*
	Senior Center		
	Meals on Wheels		
	Visiting Nurse		
	Hospice		
	CLM Behavioral Health		
	Caregivers		
	Other (please specify)		

☐ I have a Durable Power of Attorney for Health Care

☐ I have a Living Will

☐ I have a "Do Not Resuscitate" order (DNR)

☐ I have a medical ID bracelet or necklace (see your pharmacist)

Who can be contacted for a copy of these documents? Name:_____

Relationship:_____ Phone:_____