

Thank you for printing ResponseLINK's
Vial of Life.

We know how important it is to have this emergency information available for the paramedics or any other emergency services department that might respond to help you in an emergency.

Simply click the printer icon on your computer tool bar. Once printed, fill out as much information as possible. You might want to make copies for your car, purse or wallet. Once the form is completed, fold in half and place a copy on your refrigerator. Make sure the **Vial of Life** sign is in front so EMS can spot it quickly.

**If you need an
Emergency Response System or
Medication Dispenser,
please call us at**

(801) 955-4949

Name:			Medicare #:		
Address:		City:		State:	Zip Code:
Phone:	Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status	
Do you have a Living Will? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is a copy of the Living Will enclosed? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you have a Do Not Resuscitate Order (DNR)? <input type="checkbox"/> Yes <input type="checkbox"/> No			If Yes, enclose a copy		
			<i>If there is not DNR enclosed – EMS WILL RESUSCITATE YOU!</i>		
Insurance Company:	Policy #:	Secondary Ins. Co.:	Policy #:		

In Case of Emergency, Please notify:

Name:	Relationship:	Home Phone:	Cell Phone:
Name:	Relationship:	Home Phone:	Cell Phone:
Name:	Relationship:	Home Phone:	Cell Phone:
Name:	Relationship:	Home Phone:	Cell Phone:
Name:	Relationship:	Home Phone:	Cell Phone:

Medical Information

Primary Physician:	Address:		Phone:
Secondary Physician:	Address:		Phone:
Take me to the Following Hospital	Height:	Weight:	Normal Blood Pressure: / Pulse
CHECK ALL THAT APPLIES: <input type="checkbox"/> Pacemaker <input type="checkbox"/> Use Oxygen <input type="checkbox"/> Hearing Aid <input type="checkbox"/> Deaf <input type="checkbox"/> Blind <input type="checkbox"/> Glasses <input type="checkbox"/> Contact Lenses <input type="checkbox"/> Dentures <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____			
Medical History: <input type="checkbox"/> Diabetes <input type="checkbox"/> Past Stroke <input type="checkbox"/> Past Seizure <input type="checkbox"/> Heart Disease <input type="checkbox"/> COPD <input type="checkbox"/> Epilepsy <input type="checkbox"/> BP Issues <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Anemia <input type="checkbox"/> Cancer <input type="checkbox"/> Glaucoma <input type="checkbox"/> Jaundice <input type="checkbox"/> Hepatitis <input type="checkbox"/> Arthritis <input type="checkbox"/> TB <input type="checkbox"/> Asthma <input type="checkbox"/> Other _____			
Currently Being Treated For: _____			
Medication Allergies:			
Food Allergies:			
What medical problems/physical disabilities do you have?			
Past Surgeries: (Type and Date)			
Type:	Date:	Type:	Date
Type:	Date:	Type:	Date
Where do you keep your medications?			

See Medication List on other side

