VIAL OF LIFE

Complete separate form for each family member

Date Updated_____

Name:_____
Date of Birth:_____ Sex: _____
Height:___" Weight:____lbs Eyes:_____Hair:_____

I. Basic Health Info:
Blood Type: _____
Allergies to Medications:_____
_____
Current Medications & location:_____
_____
_____
Pace Maker (Model #):_____
Other implanted devices:_____

II. In Case of Emergency:
Notify, in order (Name/Relationship/Phones):
1._____
2._____
3._____
Living Will/Directive to Care Givers (Location): ____
_____
Organ Donor (yes/no):_____
Special Notes/Requests:_____
_____
_____

III. Doctor Information:
Medical Insurance/Plan:_____
Doctor:_____
Doctor Phone:_____
Hospital Preferred:_____
Specialists Names/Phones:_____
_____
_____

IV. Medical History:
Previous Operations/Dates:_____
_____
_____

Have you a history of:	Y	N	Date of Occurrence
Hearing Impaired			
Blind			
Paralysis			
Heart Attack			
Congestive Heart Failure			
Rapid/Irregular Pulse			
Abnormal Blood Pressure			
Lung Disease			
Asthma, Emphysema			
Tuberculosis			
Stroke			
Blood Transfusion			
Organ Transplantation			
Seizure Disorder			
HIV/AIDS			
Hepatitis A/B/C			
Kidney Failure			
Diabetes-Insulin/Diet			
Cancer			
Family History of Heart Disease			

BCNA

Big Country Neighborhood Association

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