Vial Of Life

Life-saving Information at www.cincinnatiredcross.org

The Vial of Life has been designed to keep important medical information about you. It is to be used by medical personnel in case of an emergency.

- Please update the information as needed. This information should remain rolled up in the vial so that it will be easily accessible.
- Update your information by downloading this form from www.cincinnatiredcross.org/vialoflife
- The Vial of Life is to be placed on the front, upper right–hand shelf of your refrigerator.
- Place the Vial of Life magnet on the refrigerator so that emergency personnel will notice it.
- **Please fill out both sides of the Vial of Life form.**

This Vial of Life has been given to you by:

PEPSI AMERICAS

American Red Cross

Greater Cincinnati office
2111 Dana Ave.
Cincinnati, Ohio 45207
513-579-3000

Private Insurance _____

Medicare # _____

Medicaid _____

Hospital Preference _____

Signed Living Will Yes No

Location _____

Date of last tetanus shot _____

Special diet _____

Language Spoken _____

Religion _____

Next of kin, contact:

Name _____

Address _____

Day Phone _____

Evening Phone _____

In case of emergency, contact:

Name _____

Address _____

Day Phone _____

Evening Phone _____

Keep Information Up to Date! Review at least every six months. Medical Data Reviewed as of Mo___Yr_____

Please Print

Name_____ Sex M F

Address_____

Phone_____

Date of Birth _____SS#_____

Blood Type _____Religion _____

Living Will on file at_____

Doctor_____ Phone _____

Doctor_____ Phone_____

History

( ) Heart Disease ( ) Hypertension

( ) Respiratory ( ) Stroke/TIA

( ) Seizures ( ) Diabetes

( ) Cancer ( ) Psychological

( ) Contacts ( ) Glasses ( ) Dentures

( ) Other_____

Recent Surgery_____ Date _____

_____

_____

Do you have an EMS-NO CPR or a DNR Form?

Yes No

Where is it located?_____

High Blood Pressure Yes No

Normal Reading_____ Date _____

Medical Conditions

(Check all that exist)

( ) No known medical conditions
( ) Abnormal EKG
( ) Adrenal Insufficiency
( ) Angina
( ) Asthma
( ) Bleeding Disorder
( ) Cardiac Dysrhythmia
( ) Cataracts
( ) Clotting Disorder
( ) Coronary Bypass Graft
( ) Dementia
( ) Heart Valve Prosthesis
( ) Diabetes/Insulin Dependent
( ) Eye Surgery
( ) Glaucoma
( ) Hearing Impaired
( ) Hemodialysis
( ) Hemolytic Anemia
( ) Hypertension
( ) Hypoglycemia
( ) Laryngectomy
( ) Leukemia
( ) Lymphomas
( ) Memory Impaired
( ) Myasthenla Gravis
( ) Pacemaker
( ) Alzheimer's
( ) Renal Failure
( ) Seizure Disorder
( ) Sickle Cell Anemia
( ) Stroke
( ) Vision Impaired

Other_____

Allergies

( ) No Known Allergies

( ) Latex ( ) Horse Serum ( ) Sulfa

( ) Aspirin ( ) Insect Stings ( ) Tetracycline

( ) Barbiturate ( ) Lidocaine ( ) X-ray Dyes

( ) Codeine ( ) Morphine ( ) Demerol

( ) Novocaine ( ) Adhesive Tape ( ) Environmental

Other _____

Medical Problems	Medication	Dosage	Frequency

Where I keep my medications _____