

# Washington Township Fire Department Emergency Information Sheet "Vial of Life"

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personnel may rely on this information and I agree not to hold emergency personnel responsible for inaccurate or out of date information. Updating this form frequently is essential for healthcare providers to deliver proper treatment. I have attached a photograph to ensure proper identification.

**SIGNATURE:** \_\_\_\_\_ **DATE COMPLETED:** \_\_\_\_\_

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex:  Male  Female

Marital Status:  Single  Married  Widowed  Divorced

Height \_\_\_\_\_ Weight \_\_\_\_\_

Social Security Number \_\_\_\_\_ Medicare Number \_\_\_\_\_

Primary Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

Secondary Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

Have you filled out an Advance Directive?  Yes  No Location \_\_\_\_\_

If yes, what type?  Do Not Resuscitate  Durable Power of Attorney for Health Care  Living Will

Notify in Emergency:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

## Medical Information

Primary Physician \_\_\_\_\_ Phone \_\_\_\_\_

Secondary Physician \_\_\_\_\_ Phone \_\_\_\_\_

Hospital Preference \_\_\_\_\_

Pharmacy and Phone number \_\_\_\_\_

Drug Allergies (specify)

\_\_\_\_\_  
\_\_\_\_\_

Reminder: Attach Recent Photograph

Washington Township Fire Department  
Emergency Information Sheet  
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**Medical Information** (continued)

Food Allergies (specify)

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What medical history (problems) do you have

- High Blood Pressure  Stroke  Diabetic  Asthma  Emphysema  
 Seizures  Epilepsy  
 Cancer if yes, type \_\_\_\_\_

Heart if yes, please give details \_\_\_\_\_

Pace Maker  Internal Defibrillator (AICD) date installed \_\_\_\_\_ model # \_\_\_\_\_

Other medical history, please detail:

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Past Surgeries (type and date)

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Do you: Wear dentures?  Yes  No

Wear glasses?  Yes  No

Wear contacts?  Yes  No

Use oxygen?  Yes  No

**Medications** (include over-the-counter medications and herbal remedies)

Name \_\_\_\_\_ Dosage \_\_\_\_\_ Times \_\_\_\_\_

Name \_\_\_\_\_ Dosage \_\_\_\_\_ Times \_\_\_\_\_

Name \_\_\_\_\_ Dosage \_\_\_\_\_ Times \_\_\_\_\_

Name \_\_\_\_\_ Dosage \_\_\_\_\_ Times \_\_\_\_\_

Name \_\_\_\_\_ Dosage \_\_\_\_\_ Times \_\_\_\_\_

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Name \_\_\_\_\_ Dosage \_\_\_\_\_ Times \_\_\_\_\_

Name \_\_\_\_\_ Dosage \_\_\_\_\_ Times \_\_\_\_\_

Name \_\_\_\_\_ Dosage \_\_\_\_\_ Times \_\_\_\_\_

Name \_\_\_\_\_ Dosage \_\_\_\_\_ Times \_\_\_\_\_

Where do you keep your medication bottles?

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Reminder: Attach Recent Photograph