VIAL OF LIFE

LIVE WELL SAN DIEGO
LIVEWELLSD.ORG

Information & Assistance
1-800-339-4661
Updated On
____/____/____

Name _____

☐ Blind ☐ Deaf ☐ Alzheimer's Disease or Related Dementia

Address _____ City _____ Zip _____

Phone # _____ Male ☐ Female ☐ Date of Birth _____

Social Security Number (last four digits) _____

Medicare Number (last four digits) _____

Other Insurance _____ Policy Number _____

Do you have an Advance Health Care Directive? Yes ☐ No ☐

If yes, location _____ Agent _____ Phone # _____

Do you have a "Do Not Resuscitate Order" Yes ☐ No ☐

Registered with Sheriff's "Take Me Home"? Yes ☐ No ☐

Emergency Contacts

Name _____ Relationship _____ Phone # and E-mail _____

Name _____ Relationship _____ Phone # and E-mail _____

Caregiver _____ Phone # and E-mail _____

Clergy _____ Phone # and E-mail _____

Pet's Information Name & Type _____

Veterinarian _____ Phone # _____

Medical Information

Primary Doctor _____ Phone # _____

Secondary Doctor _____ Phone # _____

Hospital _____ Phone # _____

Height _____ Weight _____ Blood Type _____

Normal Bood Pressure _____

Allergies to drugs or foods _____

Please list any medical conditions that apply (for example: cardiac, diabetes, hypertension, stroke) _____

Surgeries (type and date)

Do you?

Wear dentures?	Yes ☐	No ☐	Wear glasses?	Yes ☐	No ☐
Wear contacts?	Yes ☐	No ☐	Use Oxygen?	Yes ☐	No ☐
Wear hearing aids?	Yes ☐	No ☐	Wheelchair?	Yes ☐	No ☐

Other Important Emergency Information

Immunizations

Where do you keep your medications?

Medications
(Prescription, Over-the-counter Drugs, Vitamins, Herbal Supplelments)

Name	Dose-Frequency	Purpose
Name	Dose-Frequency	Purpose
Name	Dose-Frequency	Purpose
Name	Dose-Frequency	Purpose
Name	Dose-Frequency	Purpose
Name	Dose-Frequency	Purpose
Name	Dose-Frequency	Purpose
Name	Dose-Frequency	Purpose
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Please record all information in a manner easy to read by emergency medical personnel.