

# Central Jackson County Fire Protection District

## Vial of Life – Medical Information Form



### Personal Information

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Primary Language: \_\_\_\_\_ Religion: \_\_\_\_\_  
 Clergy Name and Number: \_\_\_\_\_

### Insurance Information:

Insurance Company: \_\_\_\_\_  
 Member ID: \_\_\_\_\_ Group # \_\_\_\_\_  
 Medicare/Medicaid Number: \_\_\_\_\_ SSN \_\_\_\_\_  
 Secondary Insurance Provider \_\_\_\_\_

### Emergency Contact Information

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

### Alternate Emergency Contact Information

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

### Medical Information

Allergies:							
Past Medical History: (include past surgeries)							
Blood Type:	Height:	Weight:	Dentures: Y N	Contacts or Glasses: Y N	Hearing Loss: Y N	Ambulatory: Y N	
Current Medications/Dosage/Frequency:							
Physician name and Phone Number:						Where are medications kept:	
						Hospital Preference:	

### Advanced Directives or Other Special Health Care Considerations

Do you have a Living Will Y N (include copies of these important documents in your Vial of Life)  
 Do you have a Prehospital DNR (do not resuscitate) Y N  
 Do you have a Durable Power of Attorney Y N  
 Have you consented for organ donation? Y N  
 Do you have any special health care requests emergency workers need to be aware of? Y N

If Yes, What \_\_\_\_\_ Date Completed: \_\_\_\_\_