VIAL OF LIFE

The Washington Township Fire Department would like to provide you with a tool to help ensure your family's safety and wellness by expediting your emergency medical treatment and/or transition to a physician's care. We will take this form to the hospital with you.

Complete this two-sided form for every member of your household. Make it readily available to paramedics who enter your home to treat you. The best place to post this information is on the front of your refrigerator.

Date form was completed ____________________

Name ____ Male ______ Female _____

first last

Date of Birth ______________________________________ phone number _____________

Address ____

Medicare number ______________________ Medicaid number ______________________

Insurance number _______________________

Doctor ____ phone number _____________

Home health care agency __________________________ phone number _____________

Medical equipment provider _______________________ phone number _____________

Church ____ phone number _____________

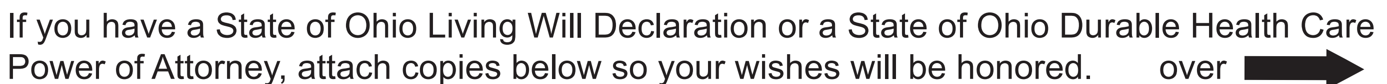
Emergency Contacts

Name ____ phone number _____________

Address ____

Name ____ phone number _____________

Address ____



If you have a State of Ohio Living Will Declaration or a State of Ohio Durable Health Care Power of Attorney, attach copies below so your wishes will be honored. over →

help ensure your family's safety and wellness

VIAL of LIFE

Name ______________________________

For more information about this and other programs or to request more *Vial of Life* forms, contact the Washington Townshi p Fire Department at (614) 652-3920.

Do you currently have or have you had any of the following?

High blood pressure	yes ____ no ____	Lung disease	yes ___ no ____
Heart disease	yes ____ no ____	Glaucoma	yes ___ no ____
Arthritis	yes ____ no ____	Pacemaker	yes ___ no ____
Cancer	yes ____ no ____	If yes, model number ___________	
Diabetes	yes ____ no ____		
Stroke	yes ____ no ____		

Do you experience confusion? yes _____ no _____

Allergies to medications: ____

Normal pulse rate ____________________ Normal blood pressure _____________________

Diagnosis by your doctor ____

____

Any other information or conditions ____

____

Medication	Dosage	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

_ _

EMS Personnel: If you transport the individual described on this form, complete the information requested below and leave this portion of the form on the refrigerator.

Date________ Time _______ Person transported to ________________________________

Person completing this form __________________________________

Employer ____