VIAL OF LIFE Medical Health Form

PLEASE PRINT CLEARLY:

Please check: Male:	Female:	
Name:		
Address:		
City	State	Zip Code
Date of Birth:		
Home Phone:		
Cell Phone:		
EMERGENCY (CONTACT	
Name:		
Home Phone:		
Cell Phone:		
Work Phone:		
ALTERNATE EMERGI	ENCY CON	TACT
Name:		
Home Phone:		
Cell Phone:		
Work Phone:		
Religious Preference (Optional)):	
Medical Evacuation Insurance: Policy Number: Phone Number:		

Name:

LIFE VIAL OF LIFE VIAL OF

This form is being provided by

S*M*A*R*T



Roll this end first to display
VIAL OF LIVE
On the outside of bottle

Primary Physician:		MEDICATIONS	
Specialty:	Name	Dosage	Frequency
Phone Number:		Ö	
Address:			
Additional Physician:			
Specialty:	-		
Phone Number:			
Address:			
Medicine and Food Allergies:			
	Herbals:		
	-		
	Vitamins:		
Medical Conditions Including any Surgeries:			
	Over the counter	Drugs:	
			_
	•	ealthcare Power of A	Attorney?
Are there <u>other medical conditions</u> that you would like	Yes	No	_
to include?			
	If yes, who is it?		
	Home Phone:		
	Cell Phone:		
Are you an organ donor Yes No			
	Work Phone:		
Do you have a Living Will, Advanced Directive or DNR?			
Yes No		REMELY IMPOR	
	K	eep Your Informat	ion
If yes, where do you keep it?		UP-TO-DATE	
		and	
		ACCURATE	
Do you wear contact lenses? YesNo			
Do you use a C-PAP? Yes No	Date Completed:		
Do you have a Pace Maker or Cardiac Defibrillator?		etely filled out place	this form in a
Yes No		place in the freezer of	
	1		