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personnel may rely on this information and I agree not to hold emergency personnel responsible for inaccurate or out of date information.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

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Medical Information (continued)

Food Allergies (specify)

_____

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:

_____

Past Surgeries (type and date)

_____

_____

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 _____

Name _____ Dosage _____ Times _____

Name _____ Dosage _____ Times _____

Name _____ Dosage _____ Times _____

Name _____ Dosage _____ Times _____

Name _____ Dosage _____ Times _____

Where do you keep your medication bottles?

_____

Reminder: Attach Recent Photograph