VIAL OF LIFE

Completed On: _____/_____/_____

Instructions

Fill out this form as completely as possible **(print clearly, please)**. If you need assistance with certain information, please contact your doctor and/or ask a neighbor for help. Fold this form and put it inside the vial. Place the vial on the top shelf of your refrigerator or refrigerator door. If you are able to speak, inform any responding emergency personnel that you have a vial. If any medical information changes, it is important to update this form. Additional forms are available from Kevin's Pharmacy. To download, go to: www.kevinspharmacy.com/vialoflife.

Name:_____
Date of birth: ___/___/_____
Address:_____
City:_____ **Zip**: _____ **Age**:_____ **Sex**: M F
S.S. #:_____ **Telephone**: ( )_____
Blood Type:_____ **Height**:_____ **Weight**:_____
Glasses: Yes No **Language spoken**:_____
Dentures: Yes No **When was your last tetanus booster shot?** ___/___/____
Do you carry an EpiPen: Yes No

Current medical conditions (list all ailments)

_____
_____
_____

Past medical conditions:

_____
_____
_____

Please list all known allergies (medications, environmental, etc.)

_____
_____

Have you ever suffered from (place a [X] next to all that apply):

[ ] Lung Disorder [ ] Nervous Disorder [ ] Heart Trouble [ ] Cancer
[ ] High Blood Pressure [ ] Diabetes [ ] Digestive Disorder [ ] Arthritis
[ ] Kidney Disease [ ] Hepatitis [ ] Blood Disease [ ] Epilepsy
[ ] Other:

_____

Your doctor's name: _____ **Telephone**: ( )_____
Hospital preference: _____

Emergency contact(s):
Name_____
Relationship_____ **Telephone**: ( )_____

Name_____
Relationship_____ **Telephone**: ( )_____

Health insurance company/provider: _____
Group #:_____ **Agreement #**:_____
Policy owner's name:_____

Do you have a living will? Yes No

If yes, person responsible to act on your behalf:
Name:_____
Location of your living will?_____
Phone: ( )_____

Durable power of attorney? Yes No

If yes, contact's information:
Name:_____
Where can we find it?_____
Phone: ( )_____

Please list ALL medications that you take (over-the-counter AND prescription)

MEDICATION NAME **DOSAGE AMOUNT** **DOSAGE FREQUENCY**

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Brought to you by:

KEVIN'S PHARMACY

We take great care to treat you like family and we do our very best to be there for you in every way possible. When you are sick, there is nothing more comforting than someone who is able to understand your challenges and meet those challenges with answers and support. We are readily available to serve you, and we are happy to go the extra mile to bring you the comfort and care that you need. To us, you are more than a customer; you are family.