

Don
Clavin
Supervisor

Dennis
Dunne, Sr.
Councilman



Council Members
DOROTHY L. GOOSBY
ANTHONY P. D'ESPOSITO
DENNIS DUNNE, SR.
THOMAS E. MUSCARELLA
CHRISTOPHER CARINI
MELISSA MILLER

KATE MURRAY
Town Clerk

JEANINE C. DRISCOLL
Receiver of Taxes

VIAL OF LIFE

MEDICAL EMERGENCY INFORMATION FORM

INSTRUCTIONS

1. Make sure form is legible and information is complete, update as necessary.
2. Place this form in Vial of Life container in your refrigerator.
3. Place Vial of Life decal on the inside of your front door.

IMPORTANT

This form should accompany patient to hospital.

NAME	LAST	FIRST	MIDDLE	SEX	<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE
ADDRESS				DATE OF BIRTH		
CITY TOWN ZIP				RELIGION		
PHONE				LANGUAGE SPOKEN		

DOCTORS TO CALL IN AN EMERGENCY

DOCTOR'S NAME	PRACTICE	TELEPHONE NUMBER
1)		
2)		
3)		
FROM WHICH HOSPITAL DO YOU RECEIVE MEDICAL CARE?		
COMMENTS:		

CURRENT MEDICAL CONDITIONS

DO YOU HAVE A PACEMAKER, DENTURES, ARTIFICIAL LIMBS, HEARING AID(S), CONTACT LENSES, ETC.? _____	
ANY KNOWN ALLERGIES? <input type="checkbox"/> NO <input type="checkbox"/> YES WHAT ARE THEY? (INCLUDE ALLERGIES TO MEDICATIONS)	
COMMENTS:	

<h1 style="text-align: center;">MEDICAL CONDITIONS</h1> <p style="text-align: center;">Check YES or NO if you are currently being treated for a medical problem.</p>		
YES	NO	Have you been treated for:
		ANEMIA
		ANGINA
		ASTHMA
		CANCER
		CATARACTS
		CONGENITAL HEART LESIONS
		DIABETES
		EMPHYSEMA
		GLAUCOMA
		HARDENING OF THE ARTERIES
		HAY FEVER
		HEART DISEASE
		HEART MURMUR
		HEPATITIS
		HIGH BLOOD PRESSURE
		LIVER CONDITION
		RHEUMATIC FEVER
		SINUS TROUBLE
		STROKE
		THYROID
		TUBERCULOSIS
		ULCERS
		OTHER
		OTHER

YES	NO	Have you been treated for:
		ANEMIA
		ANGINA
		ASTHMA
		CANCER
		CATARACTS
		CONGENITAL HEART LESIONS
		DIABETES
		EMPHYSEMA
		GLAUCOMA
		HARDENING OF THE ARTERIES
		HAY FEVER
		HEART DISEASE
		HEART MURMUR
		HEPATITIS
		HIGH BLOOD PRESSURE
		LIVER CONDITION
		RHEUMATIC FEVER
		SINUS TROUBLE
		STROKE
		THYROID
		TUBERCULOSIS
		ULCERS
		OTHER
		OTHER

[illegible]

Fill in the medications you take and any comments.

[illegible][illegible][illegible]

ADDITIONAL COMMENTS:

EMERGENCY NOTIFICATION		
IN CASE OF EMERGENCY NOTIFY:	(1) NAME	RELATIONSHIP
HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER	
IN CASE OF EMERGENCY NOTIFY:	(2) NAME	RELATIONSHIP
HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER	

MEDICAL INSURANCE INFORMATION	
SOCIAL SECURITY NUMBER	
INSURANCE COMPANY	NAME NUMBER
MEDICARE NO.	MEDICAID NO.
OTHER INSURANCE COMPANY	NAME NUMBER

NUMBER