VIAL OF LIFE

As part of the CHFD's commitment to Community Relations, we are providing Cherry Hill Residents with information on the Vial Of L.I.F.E. Program. The information contained on the reverse side will assist our EMTs/Firefighters with providing life-saving measures in case of an emergency.

The Vial of L.I.F.E is a place for you to store important information that emergency medical personnel (firefighters, EMTs, paramedics and hospital staff) may need in a time of crisis. It is designed to speak for you when you are unable to do so. The information contained in the vial will provide pre-hospital and hospital providers with essential details that will aid in providing appropriate medical treatment. It is a medical history needed by first responders such as your existing medical condition, allergies, and medication(s) currently being taken as well as containing emergency contact information. You can keep a copy of this form in your wallet, glove compartment, on your refrigerator, or in your child's pocket/backpack.

HOW TO USE YOUR VIAL OF LIFE

1. Complete the form on the back. (One vial and form for each household resident, if needed.)
2. Print your name on the labels.
3. Fold and place the form into the bottle. (All information contained on the form will be protected by HIPAA regulations.)
4. Place the bottle in your refrigerator; preferably on the door.
5. Place the enclosed Decals on the inside of your front door and also on your refrigerator so it can be seen by anyone responding to an emergency.

*It is very important to keep this information up-to-date, accurate and placed in a prominent spot on your refrigerator.

You can also maintain this information on the web at www.VialOfLife.com . You will need to go through a log-on process to use this website.

Information you may want to include:

- Identifying marks
- Past Medical History
- Current Medical Condition
- Last Hospitalization
- Dentures
- Hearing/Vision problems

Additional medical information: _____

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Cherry Hill Fire Department—Emergency Medical Services (856) 795-9805

VIAL OF L.I.F.E.—MEDICAL INFORMATION

Date:			
Name:			
Street Address:			
City:		State:	Zip:
Home Phone#:			
Lives With:			
Date of Birth:		Eye Color:	Blood Type:
Hair Color:	Sex:	Weight:	Height:
Medicare #:			
Other Insurance:			
Hospital Preference:			
Primary Language:			
Physician:		Phone #:	
Physician:		Phone #:	
	EMERGENCY CONTACTS:		
Name:		Phone #:	Cell #:
Street Address			
City:	State:	Zip:	
Relationship:			
Name:		Phone #:	Cell #:
Street Address			
City:	State:	Zip:	
Relationship:			

I have the following Advance Directive: (If you want these wishes followed, enclose a copy in this vial.)

☐ *Durable Power of Attorney for Health Care*

☐ *Pre-Hospital Do Not Resuscitate*

***MEDICAL CONDITIONS** (check all that exist)*

- ◯ *No medical conditions*
- ☐ *Angina*
- ☐ *Heart Attack*
- ☐ *HIV / AIDS*
- ☐ *Hepatitis*
- ☐ *Fractures*
- ☐ *COPD / Emphysema*
- ☐ *High Blood Pressure*
- ☐ *Cancer (Type)* _____
- ☐ *Pacemaker*
- ☐ *Stroke*
- ☐ *Asthma*
- ☐ *Diabetes/Hypoglycemia*
- ☐ *Seizures*
- ☐ *Bleeding/Clotting Disorder*
- ☐ *Kidney Problems*
- ☐ *Other* _____

Contact Lens ☐ *Yes* ☐ *No*

***ALLERGIES** (check all the apply)*

- ◯ No known allergies
- ☐ Latex
- ☐ Demerol
- ☐ Codeine
- ☐ Morphine
- ☐ Insect Stings
- ☐ Penicillin
- ☐ Aspirin
- ☐ Sulfa
- ☐ Other _____

CURRENT MEDICIATIONS As of – Date:	
Name of Prescription:	**Dosage**

Please use the reverse side for additional information on your medical history.