

MEDICAL CONTACTS			
Doctor/Phone			
Doctor/Phone			
Pharmacy/Phone			
Special Conditions			
Surgery in last 5 Years			
My most recent EKG is available () YES () NO It is located at:			
CURRENT MEDICATIONS			
<input type="checkbox"/> NO Medications <input type="checkbox"/> List all prescriptions, over the counter, vitamins, and supplements			
Condition	Medication	Dose	Times/day
ADVANCE DIRECTIVES			
My <i>Living Will</i> is on file at:			
My <i>Health Care Surrogate</i> is:			
I have an EMS-NO CPR Directive or DNR (DO NOT resuscitate form) <input type="checkbox"/> YES <input type="checkbox"/> NO It is located at:			

My Medical Info



Why do it?

Medical personnel can make the best decisions regarding emergency treatment when they know a person’s medical conditions, medications, or medical allergies. This can mean the difference between life and death in the “Golden Hour” immediately following a medical emergency.

1. Photograph

Place a clear, recent photo of just the participant into the pocket so emergency personnel can instantly identify the individual.

2. Medical Form

Fill out this medical form. Keep all your information up to date.

3. Refrigerator or Glove Box

Place the completed form in the pocket.
Vial of Life: Place the pocket on your fridge.
Yellow Dot: Place the pocket in your vehicle’s glove box.

To download this form, or for more information about **Vial of Life** and **Yellow Dot** supplies, contact **StoreSMART**.



Web: StoreSMART.com/life
 Phone: 800-424-1011 or 585-424-5300



Vial of Life and Yellow Dot Medical Information KEEP YOUR INFORMATION CURRENT <i>Download new forms at StoreSMART.com/Life</i>	
Name	
Address	
City/State/Zip	
<input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth Blood Type
Date Form was Updated:	
EMERGENCY CONTACTS	
Name/Relation	
Address	
City/State/Zip	
Phone: Work	Cell
Name/Relation	
Address	
City/State/Zip	
Phone: Work	Cell
Name/Relation	
Address	
City/State/Zip	
Phone: Work	Cell
MEDICAL INSURANCE () NONE	
#1 Medical Ins. Co. / Policy #	
#2 Medical Ins. Co. / Policy #	
<input type="checkbox"/> Medicare #	
<input type="checkbox"/> Other	

MEDICAL CONDITIONS: <i>Check all that exist</i>	
<input type="checkbox"/> NO MEDICAL CONDITIONS KNOWN	
<input type="checkbox"/> Abnormal EKG	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Adrenal Insufficiency	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Angina	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Hypoglycemia
<input type="checkbox"/> Cancer: Type _____	<input type="checkbox"/> Internal Defibrillator
<input type="checkbox"/> Cardiac Dysrhythmia	<input type="checkbox"/> Kidney Problems
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Laryngectomy
<input type="checkbox"/> Clotting Disorder	<input type="checkbox"/> Leukemia
<input type="checkbox"/> Coronary Bypass Graft	<input type="checkbox"/> Lymphomas
<input type="checkbox"/> COPD/Emphysema	<input type="checkbox"/> Malignant Hyperthermia
<input type="checkbox"/> Dementia/Alzheimer's	<input type="checkbox"/> Memory Impaired
<input type="checkbox"/> Diabetes/Insulin Dependent	<input type="checkbox"/> Myasthenia Gravis
<input type="checkbox"/> Eye Surgery	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Fractures	<input type="checkbox"/> Renal Failure
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Heart Attack: Date _____	<input type="checkbox"/> Sickle Cell Anemia
<input type="checkbox"/> Hearing Impaired	<input type="checkbox"/> Stroke
<input type="checkbox"/> Heart Valve Prosthesis	<input type="checkbox"/> Vision Impaired
<input type="checkbox"/> Hemolytic Anemia	

CONDITIONS & ALLERGIES: <i>Check all that apply:</i>		
<input type="checkbox"/> Contact Lenses	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Dentures
<input type="checkbox"/> Pregnant: Date Due _____		
<input type="checkbox"/> NO KNOWN ALLERGIES		
<input type="checkbox"/> LATEX	<input type="checkbox"/> Horse Serum	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Insect Stings	<input type="checkbox"/> Tetracycline
<input type="checkbox"/> Barbiturates	<input type="checkbox"/> Lidocaine	<input type="checkbox"/> Tetanus
<input type="checkbox"/> Codeine	<input type="checkbox"/> Morphine	<input type="checkbox"/> X-ray Dyes
<input type="checkbox"/> Demerol	<input type="checkbox"/> Novocaine	<input type="checkbox"/> Xylocaine
<input type="checkbox"/> Environmental	<input type="checkbox"/> Penicillin	

COVID VACCINE STATUS:	
<input type="checkbox"/> 1ST	<input type="checkbox"/> BOOSTER 1
<input type="checkbox"/> 2ND	<input type="checkbox"/> BOOSTER 2

OTHER CONDITIONS: