

CENTRAL OHIO “MILLENIUM VIAL OF LIFE PROGRAM”

This is a means to communicate vital information between special needs population and Emergency Personnel or caregivers in case of emergency.

The form below should be carefully completed, and using the magnetic clip provided, please place on the front of your refrigerator. Please attach any pertinent legal documents.

VIAL OF LIFE FOR: _____

Date Form Completed: _____ Date of Birth: _____

Name: _____ (M) _____ (F) _____

Address: _____

Telephone: _____ Medicare # _____

Family Doctor: _____ Medicaid # _____

Doctor’s Phone: _____ Private Insurance: _____

Preferred Hospital: _____ Insurance # _____

Normal Pulse Rate: _____ Normal Blood Pressure: _____

Home Health Care Agency: _____ Phone: _____

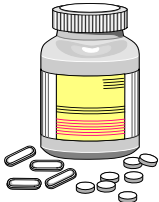
Medical Equip. Provider: _____ Phone: _____

IN CASE OF EMERGENCY CALL:

Name: _____ Name: _____

Address: _____ Address: _____

Phone: _____ Phone: _____



**Central Ohio Millennium
*Vial of Life***



**VIAL OF LIFE
PART 2**

Do you currently have any of the following?

High Blood Pressure: Yes:___ No:___ Heart Disease: Yes:___ No:___
Arthritis: Yes:___ No:___ Cancer: Yes:___ No:___
Diabetes: Yes:___ No:___ Stroke: Yes:___ No:___
Lung Disease: Yes:___ No:___ Glaucoma: Yes:___ No:___
Pacemaker: Yes:___ No:___ Model #:_____

Do you experience confusion? Yes:___ No:___

----- FOLD HERE -----

Allergies to Medications: _____
Date of your last visit to your doctor? _____
Diagnosis by your doctor? _____
Any other information or conditions: _____

Medications:	Dosage	Frequency
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____

EMS PERSONNEL: Please fill out this information and tear off, replacing it on the refrigerator, if you transport individual.

Date: _____ **Time:** _____

Person transported to: _____

Personnel's Name and Company: _____