St. Tammany Fire District 3

VIAL OF LIFE

Please Keep This Form On Or In The Refrigerator

Date Completed: _____

Last Name	First Name	Middle name	Social Security Number

Street	City	State	Zip Code	Telephone

Date of Birth	Male / Female	Height	Weight	Hair Color	Eye Color	Blood Type	Religion	Last Tetanus Shot	Organ Donor?

DO YOU HAVE A 'DO NOT RESUSCITATE' LIVING WILL REQUEST? (IF YES, PLEASE ATTACH A COPY TO THIS FORM)

Medical History

Please Circle All That Apply

Stroke Heart Attack Diabetes - Insulin Dependent? Y / N High Blood Pressure Pacemaker - Pacemaker / Defibrillator

Stents Heart Bypass Surgery Dementia Alzheimers Congestive Heart Failure Cancer-*Type:* _____

Asthma COPD Kidney Problems Seizures Psychiatric-*Type:*_____ Hearing Difficulties

Vision Difficulties Dentures - Upper / Lower Unable To Speak Pregnant Other: _____

Additional History

Other Medical Illnesses / Conditions *(Example: Heart Disease, Emphysema, Liver Disease, HIV, Hepatitis, Cancer, Etc.):*_____

_____

Surgeries: _____ Allergies: _____

Social History

Do you smoke/smoked in the past? Yes / No Pack(s) day: ___ Years: ___ | Drink alcohol? Yes / No Type: _____ Amount: _____

Physicians

Primary Care: _____ Cardiologist: _____ Other: _____

Medications

Please list the Name, Dose, and Time that the medication is taken

Emergency Contact Information

Name: _____ Address: _____ Phone: _____ Relationship: _____

Name: _____ Address: _____ Phone: _____ Relationship: _____

Insurance Information

Private: _____ Policy #: _____ Group #: _____ Medicare: _____ Medicaid: _____

For more information please visit us online: www.stfd3.com or by phone: (985) 882-5977

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