DELRAY BEACH FIRE RESCUE
COMMUNITY RISK REDUCTION
EMERGENCY DIAL 911

DELRAY BEACH FIRE RESCUE
501 W. ATLANTIC AVENUE
DELRAY BEACH, FL 33444
(561)243-7400

VIAL OF LIFE

LIFESAVING INFORMATION FOR EMERGENCIES

DATE COMPLETED: _____

PERSONAL INFORMATION

NAME (AS IT APPEARS ON YOUR ID):

_____

STREET ADDRESS: _____
CITY: _____**STATE:**_____**ZIP:** _____
PHONE: (_____)_____-_____
DATE OF BIRTH : _____/_____/_____
_____ **MALE** _____ **FEMALE**

PHYSICIAN'S NAME: _____
PHYSICIAN'S PHONE: (_____)_____-_____

EMERGENCY CONTACT NAME: _____
RELATIONSHIP:_____
EMERGENCY CONTACT PHONE: (_____)_____-_____
STREET ADDRESS: _____
CITY: _____**STATE:**_____**ZIP:** _____

INSURANCE PROVIDER: _____
POLICY NUMBER: _____
INSURANCE PROVIDER PHONE: (_____)_____-_____

PREFERRED HOSPITAL
***IN THE EVENT OF AN EMERGENCY, YOU WILL BE TAKEN TO THE NEAREST AVAILABLE HOSPITAL IN ACCORDANCE WITH MEDICAL EMERGENCY STANDARDS.**

_____

IT IS YOUR RESPONSIBILITY TO UPDATE THIS INFORMATION IMMEDIATELY FOLLOWING ANY CHANGE IN YOUR PERSONAL OR MEDICAL INFORMATION, INCLUDING YOUR CONDITION(S) OR MEDICATION(S).

MEDICAL INFORMATION

AS OF (DATE): _____

ALLERGIES (CHECK ALL THAT APPLY)

___ NO KNOWN ALLERGIES

___ (PENICILLIN, ASPIRIN, FOOD, ETC.) LIST ALL

_____

_____

MEDICAL CONDITIONS

___NO KNOWN MEDICAL CONDITIONS

___ HIV

___ ANY TYPE HEART DISEASE

___ PARKINSON'S DISEASE

___ PACEMAKER / DEFIBRILLATOR

___ DEMENTIA / ALZHEIMER'S

___ IMPAIRED HEARING / VISION

___ CANCER OF_____

___ BLOOD CLOTTING DISORDER

___ COPD

___ ASTHMA

___ SEIZURE

___ CHF

___ DIABETIC

___ STROKE (CVA

___ CHRONIC PAIN OF_____

___ OTHER CONDITION_____

BLOOD TYPE _____

CURRENT MEDICATION (S)
(PRESCRIBED AND OVER THE COUNTER)

MEDICATION	DOSE
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

RECENT SURGERY (IES)

_____

_____

_____

_____

_____

NOTES REGARDING YOUR CONDITIONS OR MEDICATIONS:

_____

_____

_____

I HAVE THE FOLLOWING (CHECK ALL THAT APPLY)

___DURABLE POWER OF ATTORNEY FOR HEALTH CARE OR HEALTH CARE PROXY

___ADVANCE DIRECTIVE OR LIVING WILL

___DNR (DO NOT RESUSCITATE OR DNR ORDERS)

COPIES OF THE ABOVE DOCUMENTS CAN BE FOUND IN THIS LOCATION:

_____

THIS LIFESAVING INFORMATION CAN HELP RESCUE CREWS DECIDED HOW TO TREAT YOU APPROPRIATELY. THIS IS ESPECIALLY IMPORTANT IF YOU MAY BE UNCONSCIOUS, IN SHOCK OR SIMPLY UNABLE TO COMMUNICATE CLEARLY. THE INFORMATION WILL BE DISCLOSED ONLY TO AUTHORIZED PERSONNEL AND SOLEY FOR THE PURPOSE OF:

- POSITIVELY IDENTIFYING THE PARTICIPANT
- DETERMING IF THE PARTICIPANT HAS A MEDICAL CONDITION THAT MIGHT INHIBIT COMMUNICATION
- ACCESS THE MEDICAL INFORMATION FORM
- ENSURING CURRENT MEDICATION AND PRE-EXISTING MEDICAL CONDITIONS ARE CONSIDERED DURING TREATMENT

YOUR SIGNATURE INDICATES YOUR VOLUNTARY PARTICIPATION IN THE "VIAL OF LIFE" PROGRAM

_____

PARTICIPANT SIGNATURE

_____

DATE