VIAL OF LIFE Emergency Medical Information Form FILE OF LIFE

Date Completed: _____

NAME:

_____ _____ _____ _____

First | Middle Initial | Last | Date of Birth

MEDICAL CONDITIONS:

- ☐ Diabetes
- ☐ Heart Disease
- ☐ Heart Failure
- ☐ Stroke
- ☐ Asthma
- ☐ COPD
- ☐ Arthritis
- ☐ Cancer
- ☐ High Blood Pressure
- ☐ Alzheimer's Disease/ Dementia
- ☐ Other (please specify)

ALLERGIES (Food, medication and/or environmental)

SURGERIES AND DATES:

Surgery:	Date:	Surgery:	Date:

PHYSICIANS:

Name:	Specialty:	Address:	Phone:

HOSPITAL PREFERENCE:

_____

HEALTH INSURANCE COMPANY:

_____

PETS:

Please contact_____(Name) at_____(Phone #) to care for my pet,_____(Pet's Name).

A community benefit sponsored by: Sun Health™

EMERGENCY CONTACTS:

Name:	Relationship:	Home Phone:	Work Phone:

MEDICATIONS:

Name:	Dosage/Strength:	Quantity:	Purpose/Special Instructions:

ADVANCE DIRECTIVES/LIVING WILL:

Do you have an Advance Directive/Living Will? ○ YES ○ NO

- *Consider filing a scanned copy of your advance directive/living will on the File of Life flash drive.*

Additional forms available at SunHealthWellness.org/VialofLife or by calling (623) 471-9355