WINDSOR HEALTH DEPARTMENT VIAL OF LIFE FORM

PLEASE PRINT CLEARLY AND PLACE IN VIAL ON REFRIGERATOR DOOR Date Completed _____

FIRST NAME	INITIAL	LAST NAME	DATE OF BIRTH	SOCIAL SECURITY #

STREET	CITY	STATE	ZIP	RELIGION

PHONE#	MALE ☐ / FEMALE ☐	HEIGHT	WEIGHT	EYE COLOR	BLOOD TYPE	DENTURES Upper ☐ Lower ☐

NATIVE LANGUAGE IF NOT ENGLISH

VISION AND/OR HEARING DIFFICULTIES

CURRENT MEDICAL CONDITIONS	3	6
1	4	7
2	5	8

CURRENT MEDICATIONS - NAME / DOSAGE / FREQUENCY

1	5	9
2	6	10
3	7	11
4	8	12

ALLERGIES TO MEDICATIONS:

DOCTORS NAMES AND PHONE NUMBERS	3
1	4
2	5

DATE OF LAST HOSPITALIZATION

PREFERRED MEDICAL FACILITY

HEALTH INSURANCE INFORMATION

ADVANCED DIRECTIVES OR OTHER INSTRUCTIONS

EMERGENCY CONTACT INFO - NAME / PHONE / ADDRESS / RELATIONSHIP

TOWN OF WINDSOR
First in Connecticut. First for its citizens.