FILE FOR LIFE INFORMATION FORM*

First Name

Last Name:

Date of Birth

MCP

Address

Phone:

APPEARANCE – If possible, **please staple a picture of yourself to this form** to help Emergency Responders identify you.

MEDICAL INFORMATION

Please indicate if you have any of the following conditions by ticking (✓) the appropriate box:

- ☐ Previous Heart Attack
- ☐ Angina
- ☐ High Blood Pressure (Hypertension)
- ☐ High Cholesterol
- ☐ Stroke
- ☐ TIA (Mini-Stroke)
- ☐ Diabetes – Insulin Dependent
- ☐ Diabetes – Non-Insulin Dependent
- ☐ Atrial Fibrillation
- ☐ Internal Pacemaker
- ☐ Internal Defibrillator
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema

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- ☐ Aneurysm
- ☐ Hemophilia
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Peripheral Vascular Disease
- ☐ Alzheimer's Disease
- ☐ Dementia
- ☐ Cancer – Please Specify Type: _____
- ☐ Surgery – Please Specify Type: _____

Please provide any additional medical information here: (Please add additional sheets if needed)

Allergies

Please indicate if you wear glasses or contacts, dentures, or have any prostheses (artificial body parts)

Do you have hearing loss? If so, please indicate to what degree:

Not applicable ○ Mild ○ Moderate ○ Profound ○

Please indicate if you wear a hearing aid (check which side you wear it on) or other assisted listening device:

L ○ R ○ Other: _____

Current Medications – It is highly recommended that you include a **printout from your pharmacist** of your current medications in this file. Each time you go on or off a medication or change the dosage **it is important to have this information updated**. Other medication information can be indicated below.

Name/location/phone number of pharmacy most commonly used

Contact Information

Doctor's Name and Phone Number

Emergency Contact:

Relationship:

Phone:

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Other Information

I have a Do Not Resuscitate (DNR) order: Yes ◯ No ◯

I have an Advance Health Care Directive: Yes ◯ No ◯

If you answered “yes” to having a DNR order or an advance health care directive, please describe where these documents can be found:

***Statement of Responsibility**

I understand I am personally responsible for the management of my **File For Life** by keeping all my records **(including medical conditions and current medications)** up-to-date.

I understand that the organization(s) involved with promoting and distributing the File For Life program and materials bear(s) no responsibility for the accuracy of the information stated on this form.

In addition, I understand that there is no guarantee that by participating in this program the File For Life information will be used in an emergency. I hold blameless all organizations involved in this program if the File For Life is not accessed in an emergency or if the information used in the file is incorrect or out-of-date due to my own error or omission.

SIGNED: _____

(participant)

DATE: _____

Please indicate here the date of the last time you updated the information in this file

_____	_____
mm/dd/yy	mm/dd/yy
_____	_____
mm/dd/yy	mm/dd/yy
_____	_____
mm/dd/yy	mm/dd/yy