

**Instructions:**

- Fill out FILE completely
- Use pencil for updating
- Only one person per FILE
- Update information at least twice annually, change "date updated" so Paramedics know information is current

- When complete, remove top portion & place folded FILE in provided sleeve
- Place sleeve on refrigerator
- Affix enclosed decal to storm door or window near front door
- If needed, ask your doctor for assistance with completing FILE

**Please Consider:**

- Those listed as emergency contacts should know location of meds & important papers and how to access
- Space in sleeve is limited - please place any other info you'd like us to know about with important papers
- Please do not place anything in front of FILE in sleeve (IE - photos) - Paramedics must be able to find & access it quickly in the event of an emergency.

**Medication Allergies**

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**Medications**

Med Name      Dose      How Often

**Example:**  
Lasix                      20 mg                      2 x per day

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**Meds Location:** \_\_\_\_\_  
\_\_\_\_\_

**Medications (continued)**

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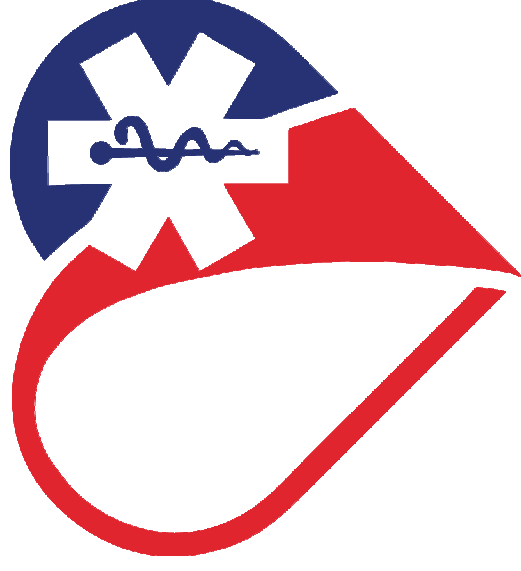


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*If you prefer, you may print a current medication list and keep it folded behind your FILE in the sleeve*

# FILE Of LIFE.

Lifesaving Information  
For Emergencies



**St. Charles County  
Ambulance District**

# Did You Know ...

- St. Charles County Ambulance District offers a safe entry program called **Rapid Access** that can prevent Paramedics and other emergency responders from entering your home by force if a medical emergency renders you unable to answer the door? For more information on this program, visit [sccad.com](http://sccad.com) or call 636.344.7600.
- The Ambulance District will gladly send a representative to your civic organization, church group, homeowners' association or other gathering to talk about safety programs offered. Presentations are offered at no charge, and cover a variety of health & safety topics. For more details or to schedule, call 636.344.7600.



Tear along perforated line

## Patient Information

Use pencil for easy updates (in English)

Name: \_\_\_\_\_  
 Age: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: (\_\_\_\_) \_\_\_\_\_  
 SSN: \_\_\_\_\_

Physician: \_\_\_\_\_  
 Phone: (\_\_\_\_) \_\_\_\_\_

Preferred Hospital: \_\_\_\_\_

Medicare #: \_\_\_\_\_  
 Ins. Co. \_\_\_\_\_  
 Policy #: \_\_\_\_\_  
 Other Ins. \_\_\_\_\_

Height: \_\_\_\_\_ ft. \_\_\_\_\_ in.  
 Weight: \_\_\_\_\_ lbs.  
 Blood Type: \_\_\_\_\_

Date Form Updated: \_\_\_ / \_\_\_ / \_\_\_

## First Emergency Contact

Name: \_\_\_\_\_  
 Relationship: \_\_\_\_\_  
 Home Phone: (\_\_\_\_) \_\_\_\_\_  
 Cell Phone: (\_\_\_\_) \_\_\_\_\_

## Second Emergency Contact

Name: \_\_\_\_\_  
 Relationship: \_\_\_\_\_  
 Home Phone: (\_\_\_\_) \_\_\_\_\_  
 Cell Phone: (\_\_\_\_) \_\_\_\_\_

## Important Papers

(If you have this paperwork and would like us to bring it to the hospital, check box and provide location)

**Do Not Resuscitate / Advance Directive**  
 Location: \_\_\_\_\_  
 **Power of Attorney Order**  
 Location: \_\_\_\_\_

I certify this form is accurate. I understand that EMS staff may rely on this and agree to hold the user harmless.

Sign: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_

## Medical History

Diagnosis Date: \_\_\_\_\_

- Asthma \_\_\_\_\_
- B/P High / Low \_\_\_\_\_
- Stroke / CVA / TIA \_\_\_\_\_
- MI / Heart Attack \_\_\_\_\_
- CABG / Cardiac Bypass \_\_\_\_\_
- CHF / Heart Failure \_\_\_\_\_
- Depression \_\_\_\_\_
- Dementia / Alzheimers \_\_\_\_\_
- Diabetes \_\_\_\_\_
- Hepatitis \_\_\_\_\_
- MRSA / VRE / ORSA \_\_\_\_\_
- HIV \_\_\_\_\_
- Seizures \_\_\_\_\_
- Other: \_\_\_\_\_
- Other: \_\_\_\_\_
- Cardiac Prob. \_\_\_\_\_ Type/Date: \_\_\_\_\_
- Central IV \_\_\_\_\_ Type/Date: \_\_\_\_\_
- Cancer \_\_\_\_\_ Type/Date: \_\_\_\_\_
- Pacemaker \_\_\_\_\_ Date Placed: \_\_\_\_\_
- Defibrillator \_\_\_\_\_ Date Placed: \_\_\_\_\_