Instructions: Fill out the form completely. Use pencil for updating. Only one person per form. Update the information on the form at least twice per year. Change the "date form updated" so your paramedics know the information is current. If necessary, you may change the headings in the phone numbers section of your Emergency Contacts (IE – ~~Cell~~ Work). Your Emergency contacts should be aware of the exact location of your Important Papers and how to access them (IE – lockbox key, safe combination, etc.). Meds Location is the place that you keep your medicine bottles. Once completed, tear along the dotted line, fold the File into thirds and insert in the provided plastic sleeve. Affix sleeve to the refrigerator. Attach the enclosed decal on a storm door or window near the front door. ***(continued on reverse side)***

Tear along perforated line

Medication Allergies

____

____

Medications

Med Name	Dose	How Often
Example:		
Lasix	20 mg	2 x per day

Meds Location: ____________________

____

Medications (continued)

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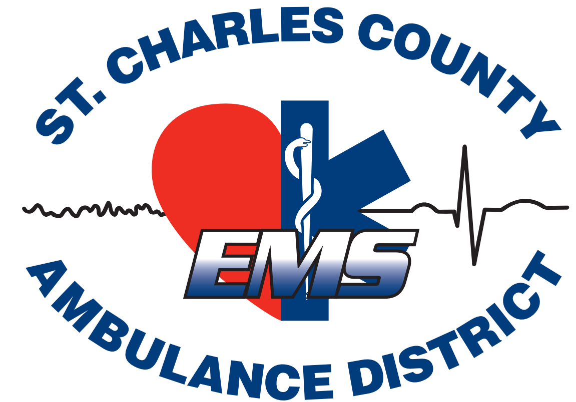
File Of L.I.F.E.

Lifesaving **I**nformation
For **E**mergencies



CALL 911

Instructions (continued)

Because space inside the plastic sleeve is limited, if you have any other medical documentation that we should know about, please place it with your **Important Papers**.

Please do not place anything in front of the File in the plastic holder (IE – photos, cards, etc.) – our crews must be able to find and access the File quickly in the event of an emergency.

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.

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

- ☐ B/P High / Low
- ☐ Stroke / CVA / TIA
- ☐ MI / Heart Attack
- ☐ CABG / Cardiac Bypass
- ☐ CHF / Heart Failure
- ☐ Depression
- ☐ Dementia / Alzheimers
- ☐ MRSA / VRE / ORSA
- ☐ Other: ___________________________
- ☐ Other: ___________________________
- ☐ Other: ___________________________
- ☐ Cardiac Prob. Type: _____________
- ☐ Central IV Type: _______________
- ☐ Surgeries (list):

____

____

- ☐ Cancer Type: _______________
- ☐ Blood Type: ____________________
- ☐ Pacemaker Model: ____________
- ☐ Defibrillator Model: ____________

- ☐ Diabetes
- ☐ Asthma
- ☐ Seizures
- ☐ Hepatitis
- ☐ HIV
- ☐ Seizures
- ☐ TB