FILE OF LIFE

The File of Life program is designed to provide emergency service personnel with time saving medical information in the home.

For other health care information or to receive additional kits please contact:

SHERIFF LANE CARTER
MOORE COUNTY SHERIFF DEPARTMENT
(910)-947-2931

DO YOU HAVE A LIVING WILL?
□ YES □ NO
DO NOT RESUSCITATE ORDER?
□ YES □ NO

FILE OF LIFE

INSTRUCTIONS

Print all information in pencil to allow periodic updating. Give special attention to current medications and allergies to medications. Update this form each time medications or general information changes.

Fold the form and insert into the file. Place the file on the door of the refrigerator. Place the enclosed sticker on your front door or window.

Have the File of Live available to give to the paramedics when they arrive.

PERSON #1

Date _____ Updated on _____
Name _____
Address _____
Phone _____ Date of Birth _____
Eye Color _____ Race _____
Height _____ Weight _____ Hair Color _____

Sex	Male ☐	Female ☐	Blind	Left ☐	Right ☐
Glasses	Yes ☐	No ☐	Contacts	Yes ☐	No ☐
Dentures	Upper ☐	Lower ☐	Mute	Yes ☐	No ☐
Hearing Aid	Yes ☐	No ☐	Deaf	Yes ☐	No ☐

Native Language _____
Religion _____
Social Security Number _____
Doctor's Name _____ Phone _____
Hospital Preference _____

IN CASE OF EMERGENCY NOTIFY

Name _____
Address _____
Phone _____ Relation _____
Name _____
Address _____
Phone _____ Relation _____

HEALTH INFORMATION

Allergies to Medication _____
Current Medications _____
_____
_____
_____
_____
Where located _____
Pharmacy Name _____

Do you have a pacemaker?	Yes ☐	No ☐
Are you an Organ Donor?	Yes ☐	No ☐
Do you have a health care surrogate?	Yes ☐	No ☐

Name _____ Phone _____

Do you have a Living Will?	Yes ☐	No ☐
Do Not Resuscitate Order?	Yes ☐	No ☐

HAVE YOU EVER BEEN TREATED FOR

AIDS	Yes ☐	No ☐	Anemia	Yes ☐	No ☐
Arthritis	Yes ☐	No ☐	Cancer	Yes ☐	No ☐
Dementia	Yes ☐	No ☐	Dialysis	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	Epilepsy	Yes ☐	No ☐
Glaucoma	Yes ☐	No ☐	Heart Condition	Yes ☐	No ☐
Hepatitis	Yes ☐	No ☐	High Blood Pressure	Yes ☐	No ☐
Respiratory	Yes ☐	No ☐	Stroke	Yes ☐	No ☐
Sickle Cell	Yes ☐	No ☐	Tuberculosis	Yes ☐	No ☐

PERSON #2

Date _____ Updated on _____
Name _____
Address _____
Phone _____ Date of Birth _____
Eye Color _____ Race _____
Height _____ Weight _____ Hair Color _____

Sex	Male ☐	Female ☐	Blind	Left ☐	Right ☐
Glasses	Yes ☐	No ☐	Contacts	Yes ☐	No ☐
Dentures	Upper ☐	Lower ☐	Mute	Yes ☐	No ☐
Hearing Aid	Yes ☐	No ☐	Deaf	Yes ☐	No ☐

Native Language _____
Religion _____
Social Security Number _____
Doctor's Name _____ Phone _____
Hospital Preference _____

IN CASE OF EMERGENCY NOTIFY

Name _____
Address _____
Phone _____ Relation _____
Name _____
Address _____
Phone _____ Relation _____

HEALTH INFORMATION

Allergies to Medication _____
Current Medications _____
_____
_____
_____
_____
Where located _____
Pharmacy Name _____

Do you have a pacemaker?	Yes ☐	No ☐
Are you an Organ Donor?	Yes ☐	No ☐
Do you have a health care surrogate?	Yes ☐	No ☐

Name _____ Phone _____

Do you have a Living Will?	Yes ☐	No ☐
Do Not Resuscitate Order?	Yes ☐	No ☐

HAVE YOU EVER BEEN TREATED FOR

AIDS	Yes ☐	No ☐	Anemia	Yes ☐	No ☐
Arthritis	Yes ☐	No ☐	Cancer	Yes ☐	No ☐
Dementia	Yes ☐	No ☐	Dialysis	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	Epilepsy	Yes ☐	No ☐
Glaucoma	Yes ☐	No ☐	Heart Condition	Yes ☐	No ☐
Hepatitis	Yes ☐	No ☐	High Blood Pressure	Yes ☐	No ☐
Respiratory	Yes ☐	No ☐	Stroke	Yes ☐	No ☐
Sickle Cell	Yes ☐	No ☐	Tuberculosis	Yes ☐	No ☐