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?	
\square YES	\square NO
DO NOT RESUSCITATE ORDER?	
\square YES	\square 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 PERSON #2 Date_____Updated on _____ Date _____Updated on _____ Name_____Address_____ Name____ Address Phone Date of Birth Phone Date of Birth

Eye Color Race

Height Hair Color Eye Color _____ Race ____ Height ____ Weight ___ Hair Color ____ Male □ Female □ Blind Left □ Right □ Male □ Female □ Blind Left □ Right □ Sex Sex Glasses Yes \(\) No \(\) Contacts Yes \(\)
Dentures Upper \(\) Lower \(\) Mute Yes \(\)
Hearing AidYes \(\) No \(\) Deaf Yes \(\) Glasses Yes \square No \square Contacts Yes \square No □ No □ $\begin{array}{cc} \text{Mute} & \text{Yes} \; \square \\ \text{Deaf} & \text{Yes} \; \square \end{array}$ Dentures Upper □ Lower □ No 🗆 No 🗆 Hearing AidYes \square No \square Deaf Yes □ No □ No □ Native Language _____ Native Language____ Religion _____ Religion Social Security Number Social Security Number ____ Doctor's Name _____Phone____ Doctor's Name _____Phone____ Hospital Preference Hospital Preference_____ IN CASE OF EMERGENCY NOTIFY IN CASE OF EMERGENCY NOTIFY Name ____ Name ____ Address ______ Relation _____ Address ______ Relation _____ Name Name____ Address ______ Relation _____ Address ______Relation _____ HEALTH INFORMATION HEALTH INFORMATION Allergies to Medication Allergies to Medication Current Medications _____ Current Medications Where located _____ Where located _____ Pharmacy Name

Do you have a pacemaker?

Are you an Organ Donor?

Yes □ No Pharmacy Name

Do you have a pacemaker?

Are you an Organ Donor?

Yes \(\simeq \) No \(\simeq \) No □ No □ No □ No □ Do you have a health care surrogate? Yes Do you have a health care surrogate? Yes □ No □ Name Phone Name Phone Do you have a Living Will? Yes □
Do Not Resuscitate Order? Yes □ Do you have a Living Will?
Do Not Resuscitate Order? No □ Yes □ No □ No □ Yes 🗆 No □ HAVE YOU EVER BEEN TREATED FOR HAVE YOU EVER BEEN TREATED FOR AIDS Yes □ No □ Anemia Yes AIDS Yes □ No □ Anemia Yes □ No □ No □

Arthritis Yes □ No □

Dementia Yes □ No □

Diabetes Yes □ No □

Glaucoma Yes □ No □

Hepatitis Yes □ No □ High Blood Pressure Yes □

Respiratory Yes \square No \square Stroke Yes \square

Sickle Cell Yes \square No \square Tuberculosis Yes \square No \square

Cancer Yes

Dialysis Yes
Epilepsy Yes

Heart Condition Yes □

No □

No □

No \square

No □

No □

No □

Arthritis Yes \square No \square

Diabetes Yes □ No □

Glaucoma Yes □ No □

Sickle Cell Yes □ No □

Respiratory Yes □ No □

Hepatitis Yes □ No □ High Blood Pressure Yes □

Dementia Yes □ No □

Cancer Yes □

Dialysis Yes □

Epilepsy Yes □

Stroke Yes

Heart Condition Yes □

Tuberculosis Yes □

No 🗆