L.I.F.E. File

LIFESAVING INFORMATION FOR EMERGENCIES

L.I.F.E. enables emergency medical personnel to quickly locate helpful information regarding your medical history in a time of crisis. It is very important that you keep this information current, accurate, and placed in a prominent location on your **REFRIGERATOR**.

1. Please fill out the L.I.F.E. File form completely.
2. Fold the L.I.F.E. File form and place it inside the magnetic pouch.
3. Enclose copies of any Advanced Directives (DNR, POLST, Living Will, etc.) in the pouch.
4. Place the L.I.F.E. pouch on the door or side of your **REFRIGERATOR**.

The L.I.F.E. File kit is available free as a public service from the Gilroy Fire Department. For a blank L.I.F.E File form, visit the Gilroy Fire Dept. website at www.cityofgilroy.org/165/Fire-Department

PERSONAL INFORMATION

Name:_____ **DOB:** _____

Address:_____ **Gender:** ☐ **Male** ☐ **Female**

City: _____ **State:**_____ **Zip Code:** _____

Phone #: __(_____)_____ **Hospital Preferred:** _____

Primary Language:_____ **Weight:**_____**lbs** (or)_____**kg**

Medical Insurance:_____ **Insurance #** _____

Advanced Directive (DNR, POLST, Living Will, Durable Power of Attorney): ☐ **Yes** ☐ **No**
For further information on Advanced Health Care Directives, visit www.sccemsagency.org

Doctor's Name:_____ **Phone:** __(_____)_____

Name:_____ **Relation:** _____

Address:_____ **Phone #:** (_____)_____

Name:_____ **Relation:** _____

Address:_____ **Phone #:** (_____)_____

Date Form Completed:_____ **Date Form Updated:** _____

Name: _____

MEDICAL HISTORY

MEDICAL CONDITIONS (check all that apply): ☐ **Stroke** ☐ **Heart/Cardiac** ☐ **Dementia**

☐ **Diabetes** ☐ **COPD** ☐ **Asthma** ☐ **Emphysema** ☐ **High Blood Pressure** ☐ **Seizures**

OTHER CONDITIONS (Medical or Surgical): _____

_____

_____

_____

Dialysis Schedule (please circle): Mon   Tues   Wed   Thurs   Fri   Sat   Sun ☐ **AM** ☐ **PM**

Dialysis Shunt: ☐ **Left**   ☐ **Right** ☐ **Both**

ALLERGIES (Medication or Environmental): _____

_____

_____

_____

MEDICATIONS

MEDICATION NAME	DOSAGE	FREQUENCY

Additional Information: *(Please write any comments or instructions, which would be helpful to emergency responders in assisting during a personal emergency)*

_____

_____

_____

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