



# Stoughton FIRE & RESCUE

*Help is a phone call away....*

## **Emergency Call 911**

**Police – Fire – Medical**

**KEEP INFORMATION UP TO DATE/ Last Updated: / /**

### ***File of Life Form***

Name:	Sex: M F
Address:	Date of Birth: / /
Own Guardian? (circle one) YES NO (if NO, fill in below)	
Guardian Name:	Home Phone #:
Address:	Work Phone #:
Guardianship Status (full, limited, etc.):	
Religion:	
Living Will on file at:	
Health Care Proxy on file at:	
Do you have a DNR/MOLST Form? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Where is it located?	
<b>EMERGENCY CONTACTS (1<sup>st</sup> responders, use these contacts)</b>	
Name:	Home Phone #:
Address:	
Relation:	Work Phone #:
Name:	Home Phone #:
Address:	
Relation:	Work Phone #:
<b>ALARM COMPANY</b>	
Alarm Company Phone #	
Pass Code for Alarm Company:	
<b>“POINT OF SAFETY”</b>	
Identify the safe place outside your home you would go in case of a fire (e.g.; neighbors driveway, tree at end of block, mailbox, etc.):	
<b>COMMUNICATION (“X” all areas that apply)</b>	
( ) Verbal language: _____	( ) Non-Verbal
( ) Uses Sign Language	( ) Uses Communication Device(s)

## MEDICAL DATA

Date Last Updated:	Blood Type:
Doctor:	Phone:
Doctor:	Phone:

Special Conditions / Remarks: Use pencil to ease making changes

### Medications


### ALLERGIES (medication, food, other...)


### Recent Surgeries

### Date


### MEDICAL CONDITIONS (check all that exist)

<input type="checkbox"/> No known medical conditions	<input type="checkbox"/> Eye Surgery	<input type="checkbox"/> Renal Failure
<input type="checkbox"/> Abnormal EKG	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Angina	<input type="checkbox"/> Heart Valve Prosthesis	<input type="checkbox"/> Sickle Cell Anemia
<input type="checkbox"/> Adrenal Insufficient	<input type="checkbox"/> Hemodialysis	<input type="checkbox"/> Stroke
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hemolytic Anemia	<input type="checkbox"/> Hearing Impaired
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Vision Impaired
<input type="checkbox"/> Cardiac Dysrhythmia	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Blind
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Laryngectomy	<input type="checkbox"/> Deaf
<input type="checkbox"/> Clotting Disorder	<input type="checkbox"/> Lukemia	<input type="checkbox"/> Other
<input type="checkbox"/> Coronary Bypass	<input type="checkbox"/> Lymphomas	_____
<input type="checkbox"/> Dementia	<input type="checkbox"/> Malignant Hypothermia	_____
<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> Memory Impaired	_____
<input type="checkbox"/> Diabetes Type 1	<input type="checkbox"/> Myasthenia Gravis	_____
<input type="checkbox"/> Diabetes Type 2	<input type="checkbox"/> Pacemaker	_____

### MEDICAL INSURANCE

<b>Med Ins Company:</b>	
<b>Policy #:</b>	
<b>Other Med Ins Company:</b>	
<b>Policy #:</b>	
<b>Medicaid #:</b>	<b>Medicare #:</b>

### PERSONAL CARE ("X" the areas where you need help)

<input type="checkbox"/> Dressing and Undressing	<input type="checkbox"/> Chewing and Swallowing
<input type="checkbox"/> Bathing or Showering	<input type="checkbox"/> Mobility
<input type="checkbox"/> Grooming / Personal Care	<input type="checkbox"/> Transferring (e.g.; bed to chair, etc.)
<input type="checkbox"/> Using the Toilet	<input type="checkbox"/> Taking Medications
<input type="checkbox"/> Eating	<input type="checkbox"/> Using the Telephone