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 ☐ NO ☐	
Where is it located?	

EMERGENCY CONTACTS (1st responders, use these contacts)

Name:	Home Phone #:
Address:	
Relation:	Work Phone #:
Name:	Home Phone #:
Address:	
Relation:	Work Phone #:

ALARM COMPANY

Alarm Company Phone #
Pass Code for Alarm Company:

"POINT OF SAFETY"

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.)?:

COMMUNICATION ("X" all areas that apply)

( ) 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)

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

MEDICAL INSURANCE	
Med Ins Company:	
Policy #:	
Other Med Ins Company:	
Policy #:	
Medicaid #:	**Medicare #:**

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

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