FILE OF LIFE

---------- FOLD TO THIS LINE ----------

First	Initial	Last	Home Phone	Mobile Phone

Street	City	State	Zip

Date of Birth	Male/Female	Weight	Height	Ethnic	Hair Color	Eye Color	Blood Type	Religion

Hearing Impaired	Visually Impaired	Speech Impaired	Mobility Impaired	Dentures	Primary Language

Have DNR, DNAR, AND, POLST or No-CPR*	Have Healthcare Power of Attorney	Have Living Will or Advance Directive	Location of Forms	Hospital Choice

Emergency Contact	Phone	Address	Relationship

Doctor	Phone	Address	Specialty

Doctor	Phone	Address	Specialty

Doctor	Phone	Address	Specialty

Allergies for medications, food, environmental, chemical, latex

Medication	Dosage	Frequency

Medication	Dosage	Frequency

Medication	Dosage	Frequency

Medication	Dosage	Frequency

Surgeries

Recent Injuries

Medical History

Implants, stints, breast, pacemaker, insulin pump, knee/hip replacement or other

Vaccinations

COVID Vaccinations Type_____ 1st _____ 2nd_____ Booster_____ Additional _____

Healthcare Insurance	Member Number	Plan Number	Group	Medicare/Medicaid

Emergency Contact / Parent / Legal guardian (name and number):	Form updated when:

*Do you have a signed POLST (Physician Orders for Life-Sustaining Treatment), DNR (Do Not Resuscitate)or No-CPR Form? **IF YES ATTACH COPY TO THIS DOCUMENT**

Additional Medications, Doctor's and Comments

Doctor	Phone	Address	Specialty
Doctor	Phone	Address	Specialty
Doctor	Phone	Address	Specialty
Doctor	Phone	Address	Specialty
Medication	Dosage		Frequency
Medication	Dosage		Frequency
Medication	Dosage		Frequency
Medication	Dosage		Frequency
Medication	Dosage		Frequency
Medication	Dosage		Frequency
Medication	Dosage		Frequency
Medication	Dosage		Frequency
Medication	Dosage		Frequency
Additional Comments, History or Background:			