AMERICAN CANYON FIRE PROTECTION DISTRICT

FILE OF LIFE

INSTRUCTIONS

The File of Life kit 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 spot on your **REFRIGERATOR**.

HOW TO USE THE FILE OF LIFE

1. Please fill out the File of Life form completely.
2. Fold the File of Life form and place it inside the magnetic pouch provided.
3. Enclose in the pouch a copy of any Advanced Directives (DNR, Living Will, etc.) that you wish to be followed.
4. Place the File of Life pouch on the door of your **REFRIGERATOR**.

The File of Life kit is available free as a public service from the American Canyon Fire Protection District.

You may obtain the kit by contacting the American Canyon Fire Protection District at (707) 551-0650, stopping by the Public Safety building at 911 Donaldson Way E during business hours, emailing admin@amcanfire.com or obtaining one from any Fire District personnel.

PERSONAL INFORMATION

Name: _____ **DOB:** _____

Address: _____ **Gender:** ❒ **Male** ❒ **Female**

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

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

Primary Language: _____ **Weight:** _____ **lbs**

Medical Insurance: _____ **Insurance #** _____

Advanced Directive (DNR, POLST, Living Will, Durable Power of Attorney): ❒ **Yes** ❒ **No**
(Please place copies of all completed Advanced Directive forms with the file of life paperwork)

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

Date File of Life Form Completed: _____

EMERGENCY CONTACT INFORMATION

Name: _____ **Relation:** _____

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

Name: _____ **Relation:** _____

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

Name: _____

MEDICAL HISTORY

MEDICAL CONDITIONS (check mark all applicable): Stroke ❒ Heart/Cardiac ❒ Diabetes ❒

COPD ❒ Asthma ❒ Emphysema ❒ High Blood Pressure ❒ Seizures ❒

OTHER CONDITIONS (past and present): _____

_____

_____

_____

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

Dialysis Shunt: ❒ Left ❒ Right ❒ Both Mastectomy: ❒ Left ❒ Right ❒ Both

MEDICAL ALLERGIES: _____

_____

_____

_____

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)*

_____

_____

_____

_____