



FILE OF LIFE

1. Fill out Medical Form (pages 2 & 3) to the best of your knowledge.
2. Place Medical Form inside plastic File of Life folder and place on refrigerator door.
3. Fill out Information Sheet (this page) and send it back to the Fire Department (**strictly voluntary**). If you submit your information sheet, we will contact you occasionally to remind you to update your information. It will also help us to document the effectiveness of the program itself. The information will also be entered into the Novi Computer-Aided Dispatch (CAD) system and will be used to prompt dispatchers to tell first responders that the File of Life is present at your location.

INFORMATION SHEET

NAME: _____

ADDRESS: _____

EMAIL: _____

SEND TO:
ATTN: Todd Seog
Novi Fire Department
42975 Grand River Ave.
Novi, Michigan 48375

Use Pencil for ease in making changes

Recent Surgery: _____

Date: _____

Do you have an EMS-NO CPR Directive or a DNR form ?
YES NO Where is it located ? _____

MEDICAL CONDITIONS

Check all that exist

- | | |
|---|---|
| <input type="checkbox"/> No known medical conditions | <input type="checkbox"/> Hemodialysis |
| <input type="checkbox"/> Abnormal EKG | <input type="checkbox"/> Hemolytic Anemia |
| <input type="checkbox"/> Adrenal Insufficiency | <input type="checkbox"/> Hepatitis-Type []] |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Laryngectomy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Cardiac Dysrhythmia | <input type="checkbox"/> Lymphomas |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Memory Impaired |
| <input type="checkbox"/> Clotting Disorder | <input type="checkbox"/> Myasthenia Gravis |
| <input type="checkbox"/> Coronary Bypass Graft | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Dementia <input type="checkbox"/> Alzheimer's <input type="checkbox"/> | <input type="checkbox"/> Renal Failure |
| <input type="checkbox"/> Diabetes/Insulin Dependent | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Eye Surgery | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Hearing Impaired | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Heart Valve Prosthesis | <input type="checkbox"/> Vision Impaired |
| <input type="checkbox"/> Other: _____ | |

ALLERGIES

- | | | |
|---|--|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Insect Stings | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Barbiturate | <input type="checkbox"/> Latex | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Lidocaine | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Demerol | <input type="checkbox"/> Morphine | <input type="checkbox"/> X-Rays Dyes |
| <input type="checkbox"/> Horse Serum | <input type="checkbox"/> Novocaine | <input type="checkbox"/> No Known Allergies |
| <input type="checkbox"/> Environmental: _____ | | |
| <input type="checkbox"/> Other: _____ | | |

MEDICAL INSURANCE

Med Ins Co: _____

Policy #: _____

Other Med Ins Co: _____

Policy #: _____

Medicaid #: _____

Medicare #: _____