CURRENT MEDICATIONS:

Include Over-the-Counter Medications

Enter "X" __ to see attached or list medications below:		
Name of Medication	Dosage	Times

Supplements: Enter "X" __ to see attached or list supplements below:

Where do you keep your medications?

Do you have a pet? __ Yes __ No / Dog __ Cat __ Other _____

Where do you keep your pet's food and supplies?

Who can we contact to care for your pet?

OTHER INFORMATION: (For example: Name of family member living with you who requires special care.)

Download POLST (Physicians Order for Life Sustaining Treatment) at www.caPOLST.org
Download this "File For Life" form at www.calaverasvolunteer.com
Download Advance Directive form at www.ag.ca.gov

sc: File for Life / Medical Information (Calaveras Volunteer Center) (03/2014)

INSURANCE/PHYSICIAN:

Insurance Co: _____

__ HMO __ PPO
__ Medicare __ Medicaid __ Medical

Primary Physician:
Name: _____
Telephone: _____

Secondary Physician:
Name: _____
Telephone: _____

Hospital Records:
Name: _____
Telephone: _____

Pharmacy:
Name: _____
Telephone: _____

EMERGENCY CONTACT:

Name: _____
Relationship: _____
Telephone: _____
Cell Phone: _____

Name: _____
Relationship: _____
Telephone: _____
Cell Phone: _____

Religious Preference: _____

FILE FOR LIFE

Information must be kept UP TO DATE

NAME: _____
Birth Year: _____
Date Updated: _____

Organ Donor?	__ Yes __ No
Do you have an Advance Directive? *(A copy must be included in file.)*	__ Yes __ No
Did you and your doctor complete a POLST?? *(PINK copy must be included in file.)*	__ Yes __ No
Air Ambulance Provider Who:	__ Yes __ No
Identifying birthmarks/scars/tattoos:	

For identification purposes, your picture must be attached here.

ALLERGIES (specify):

(Enter "X" next to any that apply.)

__ NO KNOWN DRUG ALLERGIES

__ Aspirin
__ Barbiturate
__ Codeine
__ Demerol
__ Horse Serum
__ Insect Stings
__ Latex
__ Lidocaine
__ Morphine
__ Novocaine
__ Penicillin
__ Sulfa
__ Tetracycline
__ X-Ray Dyes
__ Other: _____
__ Other: _____

__ Environmental Allergies _____
(specify): _____

__ Food Allergies _____
(specify): _____
_____

__ Other Allergies _____
(specify): _____

MEDICAL INFORMATION:

(Enter "X" next to any that apply.)

Blood Type: __ O+ __ O- __ A+ __ A-
__ B+ __ B- __ AB+ __ AB-

Do You:
__ Use Oxygen
__ Wear Contacts
__ Wear Glasses
__ Chew Tobacco
__ Have a Pacemaker
__ Wear Dentures
__ Smoke Tobacco
__ Drink Alcohol

MEDICAL CONDITIONS (specify):

(Enter "X" next to any condition that applies.)

__ NO KNOWN MEDICAL CONDITIONS

__ Abnormal EKG
__ Adrenal Insufficiency
__ Alzheimers
__ Angina
__ Asthma
__ Bleeding Disorder
__ Blood Pressure
__ High __ Low
__ Cancer
__ Cardiac Dysrhythmia
__ Cataracts
__ Clotting Disorder
__ Coronary Bypass Graft
__ Dementia
__ Diabetes
__ Insulin Dependent
__ Emphysema
__ Glaucoma
__ Hearing Impaired
__ Heart Valve Prosthesis
__ Hemodialysis
__ Hemolytic Anemia
__ Hepatitis / Type _____
__ HIV
__ Hypertension
__ Hypoglycemia
__ Leukemia
__ Lymphomas
__ Memory Impaired
__ Myasthenia Gravis
__ Pacemaker
__ Renal Failure
__ Seizure Disorder
__ Sickle Cell Anemia
__ Stroke
__ Tuberculosis
__ Vision Impaired

__ Other: _____
__ Other: _____
__ Other: _____

SURGERIES:

Date	**Type of Surgery**