File of Life

The File of Life should be maintained in a zip lock bag and kept in your backpack at all times. No one will see this private information unless there is an accident during a hike. Your fellow hikers and/or emergency personnel will look at the File of Life to notify your emergency contact and provide medical staff with your medical information.

General Information Effective Date: ______________________________
Name: ____ ___________________
Address:
____
City, State: ____
Zip Code: ____________
Phone (Home) : ______________________ (Cellular) : ______________________
DOB: __ __ /__ __/__ __ Gender: M F Height: _______ Weight: _______ Marital Status: S M W D
Health Insurance Information
Social Security No. (last 4 digits):__ __ __ __ Medicare Number: _______________________
Primary Insurance Company: __________________________
Policy Number: ___________________
Secondary Insurance Company: ________________________
Policy Number: ___________________
Have you filled out an Advance Directive for Health Care Form? Y N
If yes, name of health care agent: ______________________________
Phone: ___________________
Have you requested a Do Not Resuscitate order? Y N If Yes, please enclose/attach.
Notify in Case of Emergency
Name: ___________________________ Relationship: _______________
Phone: _________________ Name: ___________________________
Relationship: _______________ Phone: _________________
Others Living in the Home
Name: ___________________________ Relationship: _______________
Phone: _________________ Name: ___________________________ Relationship:
_______________ Phone: _________________ Pet Name/Type ____________________
Pet Sitter Name: _____________ Phone: _________________
Medical Information
Primary Physician: _____________________________ Phone: _________________
Secondary Physician: ___________________________ Phone: _________________
Specialty Physician: ____________________________ Phone: _________________
Location of Hospital Records:
____ Normal Blood Pressure:
____
Drug Allergies
(specify):____
Food Allergies (specify):
____

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Medical Information - continued

What medical problems/physical disabilities do you have?
____
____
____
____
________ List past surgeries (type and date):
____
____
____
____
____
____
____
____
________ Do you:

Wear dentures? Y N Wear glasses? Y N Wear contacts? Y N Wear a hearing aid? Y N Use oxygen? Y N

Where do you keep your medications? ____

Current Medications (list prescription, over the counter drugs, vitamins, herbal supplements, eye drops, etc.)

Name: ______________________________ Dosage: ________________ Times: ___________________
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