FILE OF LIFE® Foundation, Inc.

A Nonprofit Corporation Promoting Life Saving Ideas
PO Box G, West Suffield, CT 06093
(800) 814-1788 Fax (877) 248-5431
Website: www.folife.org

Every Second Counts!.

Emergency medical personnel arrive at the home of a senior citizen, only to find him or her unconscious or confused.

They have few facts to go on.

Does the patient have any existing conditions?

Are they taking medications?

Do they have any allergies?

The medics frantically dig through the medicine cabinet looking for medications,

The File of Life is a card which contains vital personal medical information and is kept on the outside of the resident's refrigerator in a bright red magnetic pocket, readily accessible to EMTs when they arrive on an emergency call. The medical card lists the patient's emergency medical contacts, health problems, medications taken, allergies, recent surgeries and more. A door decal is placed on the outside door to notify arriving EMTs.

There is also a compact version that can be carried in a purse or wallet.

Benefits of the FILE OF LIFE® program:

2016

- Emergency rescue teams Instantly know medical history of patient.
- Hospital emergency staff On arrival, medical data is immediately available.
- Patient Peace of mind knowing they will have prompt and quality care.

FILE OF LIFE® is Recognized by:

TRIAD, The National Sheriff's Assoc., The National Council on Aging, The National S.A.L.T. Council, A.A.R.P. Chapters and R.S.V.P. Chapters.

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What FILE OF LIFE means

$\alpha\alpha\alpha\alpha\alpha\alpha\alpha\alpha\alpha\alpha\alpha\alpha\alpha$

Benefits to first responders

- Faster help for citizens in emergencies.
- Instantly know medical history of patient.
- Corrective treatment can begin at once.
 Benefits to hospital emergency staff
- On arrival, data is immediately available to medical staff.
- No wasted time getting information from confused patient.

Benefits to each individual

- Peace of mind knowing they will have prompt and quality care.
- Easy access to potentially life-saving information.
- Assurance that proper persons will be notified quickly.

Member National National Council on Association Aging

FILE OF LIFE®

A personal medical home file prepared for emergency first responders

Instructions for using the FILE OF LIFE®

- Fill out the medical card and be sure the information is accurate and legible.
 If necessary, have someone assist you.
- Use pencil where you fill in the medications and where you date the card to allow future updates.
- When completed, place the file on the outside face of your refrigerator.
- Keep all medical data up to date.
- Whenever there is a change in medications or dosage be sure to change it on your card and redate the card.
- Take the file with you when you visit your doctor.

FILE OF LIFE® ORDER FORM

									<u> </u>	
Organization:				Date	Date: PO#:					
Contact:	Contact:					Shipping Address if Different				
Address:										
City, State, Zip:										
Phone #:										
Fax #:										
E-mail:				Date	Needed:					
	50- 99	100- 999	1,000- 4,999	1 '	10,000- 24,999	25,000- 49,999	50,000- 99,999	100,000- 499,999	Quantity	Cost
FOL-RM Refriger	ator	Magr	net Po	ouch <u>ı</u>	vith st	anda	rd card	!		
with standard card	.89	.75	.70	.62	.50	.48	.47	.46		
with no card	.79	.67	.64	.57	.45	.44	.43	.42		
additional cards	.10	.08	.06	.05	.05	.04	.04	.04		
FOL-PS Personal	Size	Pou	ich <u>w</u>	ith sta	andaro	card	!			
with standard card	.47	.40	.36	.27	.26	.23	.22	.21		
with no card	.37	.32	.30	.22	.21	.19	.18	.17		
additional cards	.10	.08	.06	.05	.05	.04	.04	.04		
FOL-DCL Door Decal .15 .13 .11 .08 .06					.05	.04	.03			
▼ File of Life with	cust	om s	pons	or im	printe	d car	ds ▼	(1,000	pcs. min.)	
FOL-RMS Refriger	ator	Magn	et Po	uch <u>w</u>	ith sp	onso	r card			
Please specify three pane	l card o	or four	panel c	ard: Th	ree Pane		Four Par	el		
with black imprinted card			.76	.67	.53	.50	.49	.47		
additional cards			.12	.10	.08	.06	.06	.05		
for each additional imprint	color	add	.10	.08	.05	.04	.03	.03		
FOL-PSS Personal	Size	Pou	ch <u>wit</u>	th sp	onsor	<u>card</u>				
with black imprinted card			.40	.30	.26	.23	.22	.21		
additional cards			.12	.10	.08	.06	.06	.05		
for each additional imprint	color	add	.10	.08	.05	.04	.03	.03		
FOL-B Benefits Sheet					<u> </u>					
Credit Card #							xpiration Da	te: -	Subtotal	
Card Holder's Name:			J				ecurity Code	<u> </u>	Shipping	
Shipping: Orders Prepaid by Check (only) Receive Free Shipping								Total		

3

Shipping: Orders Prepaid by <u>Check (only)</u> Receive Free Shipping. All other orders will be billed at current UPS Rates Terms: Net 15 Days / Minimum Order \$25.00

MasterCard, Visa, American Express & Discover Accepted

Allow 2-5 Weeks for Delivery

FILE OF LIFE® is a Registered Trademark. Any unauthorized use of the product or literature is strictly prohibited.

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Website: www.folife.org E-mail: folife@folife.org

2016

FOL-RM Refrigerator Magnet with inserted Standard Card

See Standard Card on pages 5 & 6

FILE	OF LIFE
Review At	ORMATION UP TO DATE !! **Least Every Six Months!** A REVIEWED AS OFMOYR.
Name:	Sex: M F
Address:	
Doctor:	Phone #:
Doctor:	Phone #:
EMER	RGENCY CONTACTS
Name:	Phone #:
Address:	
Name:	Phone #:
Address:	

Pouch Size 4 $^{1}/_{4}$ " X 5 $^{1}/_{4}$ "

FOL-DCL Door Decal



Decal Size 2" X 3"

Decals are ordered separately

FOL-RM File of Life Standard Card Front

Card Size 4 7/8" X 9"

いしししつへし レベー	A REVIEWED AS OF MO. YE
Name:	Se M
Address:	· ·
Doctor:	Phone #:
Preferred Hospital:	
	RGENCY CONTACTS
Name:	Phone #:
Address:	
Name:	Phone #:
Address:	
	MEDICAL DATA
Use per	ncil for ease in making changes.
Special Conditions/R	emarks:
Medicatio	on Dosage Frequency
Pharmacy:	Phone:
	Phone:
Date of Birth:	Phone: Religion:
Pharmacy: Date of Birth: Blood Type: Health Care Proxy o	Religion:
Date of Birth: Blood Type:	Religion: on file at:

FOL-RM File of Life Standard Card

Back

Use pencil for ease in market Recent Surgery:	aking changes Date:
Do you have an EMS-NO CPR D YES NO Where is i	t located ?
No known medical conditions Abnormal EKG Adrenal Insufficiency Angina Asthma Bleeding Disorder Cancer Cardiac Dysrhythmia Cataracts Clotting Disorder Coronary Bypass Graft Dementia Alzheimer's Diabetes/Insulin Dependent Eye Surgery Glaucoma Hearing Impaired Heart Valve Prosthesis Other:	Hemodialysis Hemolytic Anemia Hepatitis-Type [] Hypertension Hypoglycemia Laryngectomy Leukemia Lymphomas Memory Impaired Myasthenia Gravis Pacemaker Renal Failure Seizure Disorder Sickle Cell Anemia Stroke Tuberculosis Vision Impaired
ALLERG Aspirin Insect Sting Barbiturate Latex Codeine Lidocaine Morphine Horse Serum Novocaine Environmental: Other: MEDICAL INSU Med Ins Co: Policy #: Other Med Ins Co: Policy #:	gs Penicillin Sulfa Tetracycline X-Rays Dyes No Known Allergies
Medicaid #: Me	dicare #:

FOL-PS

File of Life Personal Size Pouch with Standard card

Pouch Size 2 ⁵/₈" X 3 ³/₄" See Standard Card on Page 8

KEEP INFORMATION UP TO DATE !! Review At Least Every Six Months! MEDICAL DATA REVIEWED AS OFMOYR.				
Name:	Sex: M F			
Address:	TVI I			
Doctor:	Phone #:			
Doctor:	Phone #:			
EME	RGENCY CONTACTS			
Name:	Phone #:			
Address:				
Name:	Phone #:			
Address:				



FOL-PS

File of Life Personal Size Standard Card

Card Size 3 1/2" X 8 1/4"

Front Back

KEEP INFORMAT Review At Least	TION UP TO Every Six N	DATE !! fonths !		Use Pencil for ease in making changes Recent Surgery: Date:
MEDICAL DATA REVIE	WED AS OF_	MOYR.		
Name:		Sex: M F		De very house on EMC NO CDD Directive on a DND form 2
Address:				Do you have an EMS-NO CPR Directive or a DNR form ? YES NO Where is it located ?
Doctor:	Phone #:			
Doctor: Phone #:				MEDICAL CONDITIONS
EMERGENC	Y CONTAC	CTS		Check all that exist
Name:	Phone #:		Fold	No known medical conditions Hemodialysis Abnormal EKG Hemolytic Anemia
Address:				Abnormal EKG Hemolytic Anemia Adrenal Insufficiency Hepatitis-Type []
Name:	Phone #:			Angina Hypertension
Address:				Asthma Hypoglycemia
	AL DATA			Bleeding Disorder Laryngectomy Cancer Leukemia
Use pencil for ea		hanges.		Cardiac Dysrhythmia Lymphomas
Special Conditions/Remarks:				Cataracts Memory Impaired
				Clotting Disorder Myasthenia Gravis
		_		Coronary Bypass Graft Pacemaker Dementia Alzheimer's Renal Failure
				Diabetes/Insulin Dependent Seizure Disorder
<u>Medication</u>	Dosage	Frequency	Fold	Eye Surgery Sickle Cell Anemia
				Glaucoma Stroke
				Hearing Impaired Tuberculosis Heart Valve Prosthesis Vision Impaired
				Heart Valve Prosthesis Vision Impaired Other:
				ALLERGIES Aspirin Insect Stings Penicillin
				Barbiturate Latex Sulfa
				Codeine Lidocaine Tetracycline
			<u>_</u>	Demerol Morphine X-Rays Dyes Horse Serum Novocaine No Known Allergies
			Fold	Horse Serum Novocaine No Known Allergies Environmental:
				Other:
Preferred Hospital:				MEDICAL INSURANCE
Pharmacy:	Phone:			Med Ins Co:
Date of Birth:	Blood Type:			Policy #:
Religion:				Other Med Ins Co:
Health Care Proxy on file at:				Policy #:
Living Will on file at:	V OF CARR FOR ARE	NITIONAL INFORMATION		Medicaid #: Medicare #:
® FILE UP LIFE SEE BAC	N OF CARD FOR ADL	DITIONAL INFORMATION		THOUSANT THE

FOL-RMS Refrigerator Magnet with Sponsor Card Inserted

FILE OF LIFE

Compliments of Union Hospital

KEEP INFORMATION UP TO DATE!!

Name:

Address:

Doctor:

Phone #:

Preferred Hospital:

EMERGENCY CONTACTS

Name:

Phone #:

Phone #:

With Inserted Three Panel Sponsor Card

FILE OF LIFE

Emergency Dial 911

With Inserted
Four Panel
Sponsor Card

Aging & Disability Resource Center of Brown County

Address: Name:

Address:

KEEP INFORMATION UP TO DATE

FOL-RMS Three Panel Sponsor Card Front Card Size 4 7/8" X 9"

Compliment	Imprint Area ³ / ₈ " X 4 ¹ / ₂ "					
Name:	RMATION UP TO	Sex:	-			
Address:		MF	-			
Doctor:	Phone #:		-			
Preferred Hospital:			-			
·	ENCY CONTAC	CTS	-			
Name:	Phone #:		_			
Address:			_			
Name:	Phone #:		-			
Address:			Fold			
Use pencil fo	MEDICAL DATA as of Mo. Yr. Use pencil for ease in making changes. Special Conditions/Remarks:					
Medication	Dosage	Frequency	- - -			
			- - -			
			_ Fold - - -			
Pharmacy:	Phone:		- - -			
Date of Birth:			-			
Blood Type:	Religion:		-			
Health Care Proxy on file	at:		_			
Eiving Will on file at:	EE BACK OF CARD FOR ADD	DITIONAL INFORMATION	N			

FOL-RMS Three Panel Sponsor Card Back

Use pencil for ease in measurement Surgery:	paking changes Date:					
Do you have an EMS-NO CPR Directive or a DNR form ? YES NO Where is it located ? MEDICAL CONDITIONS						
Check all that No known medical conditions Abnormal EKG Adrenal Insufficiency Angina Asthma Bleeding Disorder Cancer Cardiac Dysrhythmia Cataracts Clotting Disorder Coronary Bypass Graft Dementia Alzheimer's Diabetes/Insulin Dependent Eye Surgery Glaucoma Hearing Impaired Heart Valve Prosthesis Other:						
ALLERG Aspirin	gs Penicillin Sulfa Tetracycline X-Ray Dyes No Known Allergies					
Other Med Ins Co: Policy #: Medicaid #: Medicaid #:	edicare #:					

FOL-RMS

Four Panel Sponsor Card Front

Card Size 4 7/8" X 11 7/8"

Imprint Area 2 ¹/₂" X 4 ¹/₂"

We can size and arrange any submitted artwork including typesetting.

11 ⁷/₈"

Emergency Dial 911



KEEP INFORMATION UP TO DATE

Fold

Name:		Sex M F			
Address:					
	Date of E	Birth: / /			
EMERGEN	CY CONTAC	TS			
Name:	Home Phone #:				
Address:					
Relation:	Work Phone #:				
Name:	Home Phone #:				
Address:					
Relation:	Work Phone #:				
MEDIC	CAL DATA				
Last Updated: Mo.		od Type:			
Doctor:	Phone #:				
Preferred Hospital:					
Use pencil for ea	ase in making ch	anges.			
Special Conditions/Remark	ks:				
Special Conditions/Remar	ks:				
Special Conditions/Remar	ks:				
Special Conditions/Remar	ks:				
Special Conditions/Remar	ks:				
Special Conditions/Remark	ks: Dosage	Frequency			
		Frequency			

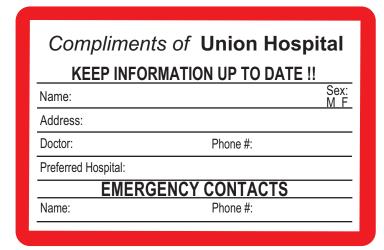
FOL-RMS Four Panel Sponsor Card Back

Use pencil for ease in making	changes	
Medication	Dosage	Frequency
Recent Surgery:		Date:
		2410.
Dull's land		
Religion:		
Living Will on file at:		
Health Care Proxy on file at:		
Do you have an EMS-NO C		or a DNR form?
YES NO Where	is it located?	
MEDICAL	CONDITIO	NC
	all that exist	NS
No known medical condit		nodialysis
Abnormal EKG		nolytic Anemia
Adrenal Insufficiency		atitis-Type []
Angina		ertension
Asthma		oglycemia kemia
Bleeding Disorder		remia iphomas
Cancer Cardiac Dysrhythmia		nory Impaired
Cataracts		sthenia Gravis
Clotting Disorder		emaker
Coronary Bypass Graft	Ren	al Failure
Dementia Alzheimer's	₃ ☐ Seiz	zure Disorder
Diabetes/Insulin Depende		de Cell Anemia
Eye Surgery	_	ke
Glaucoma	ш	erculosis
Hearing Impaired	U VISIO	on Impaired
Heart Valve Prosthesis Other:		
	ERGIES_	
	ct Stings	Penicillin
☐ Barbiturate ☐ Late ☐ Lido		Sulfa
	caine ohine	Tetracycline X-Ray Dyes
	ocaine	No Known Allergie
☐ Environmental:		
Other:		
	<u> INSURAN</u>	CE
Med Ins Co:		
Policy #:		
Other Med Ins Co:		
Policy #:		
Medicaid #:	Medicare #:	
iviedicalu #.	ivieuicare #:	

FOL-PSS Personal Size Pouch with Sponsor Card Inserted

Pouch Size 2 5/8" X 3 3/4"

Three Panel Layout Card





FOL-PSS Personal Size Pouch with Sponsor Card Inserted

Pouch Size 2 ⁵/₈" X 3 ³/₄"

Four Panel Layout Card





Personal Size Card Front & Back

Size 3 ¹/₂" X 8 ¹/₄" Three Panel "Layout" Card

Imprint Area 5/16" X 3 1/4"

Compliments of	of Union Hospita	Use Pencil for ease in making changes Recent Surgery: Date:
KEEP INFORMA	TION UP TO DATE !!	
Name:	S	ex: F
Address:		Do you have an EMS-NO CPR Directive or a DNR form ? YES NO Where is it located ?
Doctor:	Phone #:	No Where is a located :
Preferred Hospital:		MEDICAL CONDITIONS
EMERGEN	CY CONTACTS	Check all that exist
Name:	Phone #:	Fold No known medical conditions Hemodialysis
Address:		— Abnormal EKG Hemolytic Anemia Adrenal Insufficiency Hepatitis-Type []
Name:	Phone #:	Angina Hypertension
Address:		Asthma Hypoglycemia
MEDICAL DATA as	of Mo. Yr.	Bleeding Disorder Laryngectomy Cancer Leukemia
	ase in making changes.	Cardiac Dysrhythmia Lymphomas
Special Conditions/Remarks:		Cataracts Memory Impaired
		Clotting Disorder Myasthenia Gravis
		Coronary Bypass Graft Pacemaker
		Dementia Alzheimer's Renal Failure Diabetes/Insulin Dependent Seizure Disorder
Medication	Dosage Frequenc	Eye Surgery Sickle Cell Anemia
		Glaucoma Stroke
		Hearing Impaired Tuberculosis
		Heart Valve Prosthesis Vision Impaired
		Other:
		— ALLERGIES
		Aspirin Insect Stings Penicillin
		Barbiturate Latex Sulfa
		Codeine Lidocaine Tetracycline
		Demerol Morphine X-Rays Dyes
		— IFold Horse Serum Novocaine No Known Allergies Environmental:
		— Other:
Pharmacy:	Phone:	MEDICAL INSURANCE
Date of Birth:		Med Ins Co:
	Religion:	Policy #:
Health Care Proxy on file at:		Other Med Ins Co:
Living Will on file at:		Policy #:
	ACK OF CARD FOR ADDITIONAL INFORMA	Medicaid #: Medicare #:

FOL-PSS Four Panel Sponsor Card Card Size 3 1/2" X 8 1/4"

Imprint Area 1 ${}^{3}/_{4}$ " X 3 ${}^{/1}/_{4}$ "

Emergency Dial 911				<u> </u>	harmacy:	Ph	one:
Emerge	elicy Dial 9	11		_ _	ate of Birth:		
				E	lood Type:	Religion:	
				-	lealth Care Proxy	on file at:	
	IDP			-	iving Will on file a	at:	
Aging KEEP INFORM	& Disability Resource of Brown County			\ <u>F</u>	o you have ar ES NO [Where is it	ective or a DNR form ? located ? DATE:
KLLI INI OKI	IATION OF TO	DAIL	F	Fold _			
MEDICAL DATA REV	IEWED AS OF	MO.	YR.	-	M	EDICAL CONF	NITIONIC
Name:			Sex: M F	-	IVI	EDICAL COND Check all that e	exist
Address:] [No known m Abnormal El	edical conditions	Hemodialysis Hemolytic Anemia
Doctor:	Phone #:				Adrenal Insu		Hepatitis-Type []
Doctor:	Phone #:]	Angina		Hypertension
	NCY CONTAC	CTS			<pre></pre>	L sorder Γ	Hypoglycemia Laryngectomy
Name:	Phone #:			į	Cancer		Leukemia
Address:					☐ Cardiac Dys ☐ Cataracts	rhythmia L	Lymphomas Memory Impaired
Name:	Phone #:		F	Fold	Clotting Disc	order [Myasthenia Gravis
Address:] [Coronary By	rpass Graft Alzheimer's	☐ Pacemaker ☐ Renal Failure
MFDI	CAL DATA					sulin Dependent	Seizure Disorder
Use pencil for e	ease in making	changes.]	Eye Surgery		Sickle Cell Anemia
Special Conditions: Remarks:					☐ Glaucoma☐ Hearing Imp	L aired Γ	Stroke Tuberculosis
				اِ ا	Heart Valve		Vision Impaired
					Other:	ALLEDOU	-0
Medication	Dosage	Frequenc	_	Fold [Aspirin Barbiturate Codeine Demerol	ALLERGIE Insect Stings Latex Lidocaine Morphine Novocaine	_
					Environmenta	ll:	
					Other:	EDIOAL INOLI	DANOE
				-	Med Ins Co:	EDICAL INSU	RANCE
				-			
			—	-	Policy #:		
	+		—	-	Other Med Ins Co	0:	
			—	-	Policy #:		
® EU E OE LIEE SFE B	SACK OF CARD FOR ADDIT	IONAL INFORMATI	ION		Medicaid #:	Medi	icare #: