File of Life Form
Montage at Mission Hills Homeowners Association

This form is to provide key personal life-saving information to assist emergency medical response personnel in understanding your personal health and medical needs during an emergency. Please 1.) complete the form and 2.) place the form in a sealable plastic bag or container 3.) place the bag inside your refrigerator or affixed to the front of side of your refrigerator in a visible area. The File of Life Program is nationally recognized and recommended and used by the Cathedral City Fire Department.

Personal Information

Name	Date Form Completed	Preferred Language

☐	Male	☐	Female		☐	Single	☐	Married	☐	Divorced	☐	Widowed
Gender				Date of Birth	Marital Status							

Montage Address	Street	City	State	Zip

Home Phone	Work Phone	Cell Phone

Medicare Number	Secondary HMO / Insurance Company	Policy Number

Do you have an advanced Directive (Living Will, Durable Power of Attorney for Health Care or similar document? Yes ☐ No ☐
If so, who did you name to make healthcare decisions for you (if anyone) or where can a copy of the document be found?

POA / Health Care Contact Name	Phone	Document Location

Emergency Contact Name	City/State	Relationship	Phone
Emergency Contact Name	City/State	Relationship	Phone
Primary Care Physician	City/State		Phone
Secondary Physician	City/State		Phone
Clergy Name	City/State		Phone
Pet Names		Pet Sitter Name	Phone

Medical Information

Where are hospital records located?					
Where do you keep medications?					
Drug Allergies. If yes please list	Yes	☐	No	☐	
Food Allergies. If yes please list	Yes	☐	No	☐	

Vial of Life Form

Medical Information

Normal Blood Pressure				Height				Weight			
Dentures	Yes ☐	No ☐		Wear Contact Lens	Yes ☐	No ☐		Wear Glasses	Yes ☐	No ☐	
Hearing aids	Yes ☐	No ☐		Use Oxygen	Yes ☐	No ☐					

Current Medications (Include prescription and over the counter drugs, vitamins and herbal supplements)

Drug Name	Dosage / Time	Drug Purpose

Medical History (What medical problems/physical disabilities do you have? For example heart problems, diabetes, high blood pressure, etc.)

Past Surgeries (Type and date)