MINNESOTA
COUNCIL ON DISABILITY

Medical Information

Date

Date this information was completed: _____

Medical Conditions

Include information such as diabetes, heart condition, etc.

Condition/Disability: _____

Condition/Disability: _____

Condition/Disability: _____

Condition/Disability: _____

Allergies

Allergy: _____

What happens: _____

Allergy: _____

What happens: _____

Allergy: _____

What happens: _____

Allergy: _____

What happens: _____

Medications

Name of Medication: _____

Reason: _____

Dose and Schedule: _____

Name of Medication: _____

Reason: _____

Dose and Schedule: _____

Name of Medication: _____

Reason: _____

Dose and Schedule: _____

Name of Medication: _____

Reason: _____

Dose and Schedule: _____

Name of Medication: _____

Reason: _____

Dose and Schedule: _____

Medical Equipment

Include information such as wheelchair, hearing aids, oxygen, etc.

Type of Equipment: _____

Type of Equipment: _____

Type of Equipment: _____

Type of Equipment: _____

Type of Equipment: _____