Accessibility/Medical Support Form

Date of Request: _____
Time of Request: _____
Reception Staff Name: _____

Member Information
Name: _____
Date of Birth: _____
Membership ID: _____
Phone: _____
Email: _____

Emergency Contact:
Name: _____ Phone: _____

2. Do you have a Personal Emergency Response Plan? Yes
No N/A

3. Type of Accessibility Need (Check all that apply)

☐ Mobility Impairment (wheelchair, walker, cane)

☐ Visual Impairment (blind, low vision)

☐ Hearing Impairment (deaf, hard of hearing)

☐ Cognitive or Developmental Disability

☐ Dual Sensory Impairment (visual + hearing)

☐ Other: _____

4. Assistance Required During Evacuation

Evacuation support:

☐ Requires staff assistance

☐ Can evacuate independently

Mobility aids:

☐ Wheelchair ☐ Walker ☐ Cane ☐ Other: _____

Specific instructions for staff (e.g., guide to exit, avoid stairs, maintain medications close, etc.):

_____
_____

_____
_____

_____
_____

Description Support Needed

(Include specific details, location, equipment, or communication method needed)

(Choose preferred method or describe special instructions)

☐ Verbal instructions

☐ Written instructions

☐ Visual alerts / gestures

☐ Staff-assisted guidance

☐ Other: _____

5. Medical Information

Current Medical Conditions:
_____

Medications / Equipment Needed:
_____

Special Considerations During Physical Activity or Evacuation:

_____
_____

Emergency Response Instructions (if applicable):

_____
_____

_____
_____

_____
_____

6. Follow-Up / Confirmation

Confirmation with member completed: ☐ Yes ☐ No

Health & Safety Staff Signature: _____ Date: _____