



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: _____