HURLBUT™
CARE COMMUNITIES
Let our family care for yours

Please answer the following questions. A screener will then check and record your temperature.

1. What is the date of your most recent COVID-19 test? Were the results positive, negative or inconclusive? Date: _____ or N/A ____ Positive ____ Negative ____ Inconclusive

2. Have you been in contact with any person who has tested positive for COVID-19, been quarantined or who has had symptoms of COVID-19 within the last 14 days?
   ____ YES ____ NO

3. Have you experienced any of the following in the last 14 days?

- Fever _____
- Cough _____
- Loss of smell or taste _____
- GI symptoms such as nausea, vomiting or diarrhea _____

4. Have you traveled to or from any of the restricted areas in the last 14 days?
   (*Please see attached list which is updated weekly) YES ____ NO ____

I have received and will follow these guidelines. I understand that failure to follow these guidelines may result in my attendance being restricted for any future outdoor events at the facility.

Temperature: _____

Name (PRINT): _____

Signature: _____

Name of person conducting screening: _____ Date: _____

Please refer any questions to nursing supervisor.

HCC 7/2020