International Land Border Illness or Death Investigation Form
U.S. Centers for Disease Control and Prevention

QARS Unique ID #: _____

Section 1. Quarantine station notification

Type of notification:	☐ Traveler illness ☐ Traveler death	Date of initial notification:	_____/_____/_____ *(mm / dd / yyyy)*	Time of initial notification:	: *(hh : mm)*
Detection of travelers illness or death:	☐ Detected on conveyance or at POE	☐ Detected after departing POE	☐ Detected while exiting US		
Port of Entry: (or city/region)	State:	Notified by: (name of person)			
Notified by: (name of agency)	Phone:	Email:			

Conveyance type:
☐ Personal vehicle ☐ Commercial/Cargo vehicle ☐ Pedestrian/Bike ☐ Ambulance ☐ Train ☐ Bus/Van

Did illness occur en route?	☐ No ☐ Yes ☐ Unknown	If illness occurred en route, was quarantine station notified **prior to arrival**?	☐ No ☐ Yes	If illness occurred en route, was illness reported to another agency **prior to arrival**?	☐ No ☐ Yes ☐ Unknown	If yes, name of agency notified:

Section 2. Information on signs and symptoms of ill or deceased person

Brief history of present illness:

Signs, Symptoms, and Conditions (Check all that apply) :

☐ Fever (≥100˚F or ≥37.8°C) **OR** recent history of fever Onset date: ___/____/_____ If measured, maximum temperature: _____ ˚F/˚C	☐ Sore throat	☐ Decreased consciousness
	☐ Difficulty breathing / shortness of breath	☐ Recent onset of focal weakness and/or paralysis
☐ Rash Onset date: ___/____/_____ Where rash started: ☐ Head ☐ Trunk ☐ Extremities Current distribution: ☐ Head ☐ Trunk ☐ Extremities Appearance: ☐ Red/flat ☐ Red/raised ☐ Fluid/Pus filled ☐ Other: _____ Contact with someone with a rash/chicken pox/rubella in the last 3 weeks? ☐ No ☐ Yes ☐ Don't know	☐ Swollen glands	☐ Unusual bleeding Onset date: ___/____/_____
	☐ Severe vomiting	☐ Obviously unwell
	☐ Severe diarrhea Onset date: ___/____/_____ With blood: ☐ No ☐ Yes Number of times in past 24 hrs: _____	☐ Asymptomatic
		☐ Other: _____
	☐ Jaundice Onset date: ___/____/_____	☐ Cluster of illnesses **§** Cluster number: _____
☐ Conjunctivitis / eye redness	☐ Headache	
☐ Persistent cough Onset date: ___/____/_____ With blood: ☐ No ☐ Yes	☐ Neck stiffness	**§**Each ill or deceased person in the cluster should have a separate illness or death report which QARS will link to other ill and/or deceased persons in the cluster

Presumptive Diagnosis:

☐ Disease of public health importance
☐ Condition of public health interest / Unknown, needs follow-up

OR

☐ Condition not requiring public health follow-up:
Affected system: ☐ Gastrointestinal ☐ Cardiovascular ☐ Musculoskeletal ☐ Neurologic ☐ Psychiatric ☐ Respiratory ☐ Genitourinary ☐ Dermatologic

If disease of public health importance or condition of public health interest, proceed to next section.
If condition not requiring public health follow-up, stop here.

Section 3. General information about the ill or deceased person

Paternal/Last name:	Maternal name:	First name:

Middle name:	Married name:	Aliases:

Gender:	☐ Male ☐ Female
Border commuter:	☐ No ☐ Yes ☐ Unknown

Race:
☐ White ☐ American Indian/Alaskan Native ☐ Asian
☐ Black ☐ Native Hawaiian/Pacific Islander ☐ Unknown
☐ Other: _____

Ethnicity:
☐ Hispanic
☐ Non-Hispanic
☐ Unknown

Type of traveler:
☐ Crew
☐ Passenger
☐ N/A

Frequency of border crossing:	Passport #:	Alien #:	Passport country:

Legal status:
☐ Immigrant ☐ Resident Alien ☐ Illegal Alien ☐ US Citizen
☐ Foreign Citizen ☐ Refugee/Asylee ☐ Unknown

Visa type:
☐ Student/Exchange ☐ Temporary worker: agriculture ☐ Business
☐ Tourist (includes VFR) ☐ Humanitarian Parole ☐ Diplomatic
☐ Temporary worker: skilled labor ☐ Witness/Informant ☐ N/A - no visa

Date of birth: _____/_____/_____ *(mm / dd / yyyy)*	Age: _____ ☐ Days ☐ Weeks ☐ Months ☐ Years	Country of birth:

Home address:	City:	State/Province:	Country of residence:

ZIP/Postal code:	Home telephone number:	E-mail:	If visiting, total duration of US stay: _____ ☐ days ☐ months ☐ weeks ☐ years

Contact in US - Address/hotel: ☐ Same as above (home address)	Contact in US - City:	Contact in US - State/Province:	Contact phone in US: ☐ Cell	Number of days reachable at contact phone: _____ days ☐ Permanent number

Contact information: ☐ None ☐ Unknown	Emergency contact name:	Emergency contact relationship:	Emergency contact phone:

Section 4. Border Crossing Information

Express lane? ☐ No ☐ Yes ☐ Unknown	Attempted entry outside an official POE? ☐ No ☐ Yes ☐ Unknown	Was the traveler coming from an airport? ☐ No ☐ Yes ☐ Unknown

Make/Model/Year:	License plate #:	State issued:	Country issued:

Company owned? ☐ No ☐ Yes	If yes, specify:	Rental? ☐ No ☐ Yes	If yes, specify:
Did conveyance transport cargo? ☐ No ☐ Yes	If yes, specify:		

Departure city & address: ☐ Unknown	Departure date: _____/_____/_____ *(mm / dd / yyyy)*	Departure time: : *(hh : mm)*
Destination city & address: ☐ Unknown	Expected arrival date: _____/_____/_____ *(mm / dd / yyyy)*	Expected arrival time: : *(hh : mm)*

Route information:

	From (City/Country)	To (City/Country)	Duration of stay	Significant stops	Name of commercial carrier, if applicable	Flight/Bus/Train No.
Segment 1:						
Segment 2:						
Segment 3:						

Section 5. Traveling companions and other contacts of ill or deceased person

If traveling by conveyance, does anyone else on the conveyance have similar illness? ☐ No ☐ Yes ☐ Unknown	Number of traveling companions: _____	Are any traveling companions ill? ☐ No ☐ Yes ☐ N/A (no companions)

Number of driver(s): _____	Name of driver(s): 1. _____ 2. _____ 3. _____	Driver's license number(s): 1. _____ 2. _____ 3. _____

Section 6. Exposure history of ill or deceased person

Occupation:

During **3 WEEKS** prior to date of illness onset, did traveler have contact with:

Other ill individuals?	☐ No ☐ Yes ☐ Unknown	If Yes, ill persons' diagnoses or description of illness:	
Animals or birds? (e.g., visits to zoo, animal market, poultry farm, etc.)	☐ No ☐ Yes ☐ Unknown	If Yes, in which country did contact occur?	Describe nature of contact:
Other exposures? (e.g., chemical, powder, radiation, etc.)	☐ No ☐ Yes ☐ Unknown	If Yes, describe nature of contact:	

Section 7. Vaccination, past illness, and treatment history of ill or deceased person

Does traveler have underlying conditions which may explain the symptoms:	☐ No ☐ Yes ☐ Unknown	If yes, describe:

Vaccination history (check all that apply):	☐ Measles ☐ Varicella ☐ Rubella ☐ Pertussis ☐ Mumps ☐ Influenza, last received: ____/_____ ☐ Meningococcal ☐ Hepatitis A ☐ Hepatitis B (*mm/yyyy)*		
Past illness history (check all that apply):	☐ Measles ☐ Varicella ☐ Rubella ☐ Pertussis ☐ Mumps		
Currently taking medications?	☐ No ☐ Yes ☐ Unknown	If Yes, indicate category(ies) of the medication(s) (check all that apply): ☐ Antibiotic/antimicrobial ☐ Fever reducing medication ☐ Other	If Yes, indicate name of medication(s): 1. _____ 2. _____ 3. _____ 4. _____
Treatment given prior to travel?	☐ No ☐ Yes ☐ Unknown	If Yes, what was done and by whom?	
Treatment given during travel, but before crossing the border?	☐ No ☐ Yes ☐ Unknown	If Yes, what was done and by whom?	
Treatment given at POE?	☐ No ☐ Yes ☐ Unknown	If Yes, what was done and by whom?	
Treatment given after crossing the border?	☐ No ☐ Yes ☐ Unknown	If Yes, what was done and by whom?	

Section 8. Disposition of ill or deceased person

Ill or deceased person was: (check all that apply)	☐ Advised to seek medical care ☐ Released to continue travel ☐ EMS called ☐ Refused entry ☐ Transported to hospital ☐ MOA activated ☐ Isolated ☐ Deceased ☐ Detained by ICE/CBP – Detained at: _____ ☐ Referred to: _____

Section 9. Agencies contacted

(*Agency type key*: **F** = Federal, **S** = State, **L** = Local, **P** = Private, **A** = Airport, **X** = Foreign)

Contact name & title	Agency	Type	Phone	E-mail

Additional comments or findings:

☐ Investigation closed Date: _____