

International Air Travel Illness or Death Investigation Form
U.S. Centers for Disease Control and Prevention

Section 1. Quarantine station notification

Section 5. Exposure history of ill or deceased person

Notified by: (name of person)	Visited Urban Areas?	Visited Rural Areas?	How long ago?	Activities (e.g. student, missionary, personal or business travel, etc.)	Exposure to animals?*	Exposure to ill persons?
Notified by: (name of agency)	Yes No	Yes No			Yes No	Yes No
Type of notification:	Date of notification:			Time of initial notification: (24 hours)	Yes No	Yes No
<input type="checkbox"/> Traveler illness						
<input type="checkbox"/> Traveler death						
	Yes No	Yes No			Yes No	Yes No

For Illness Report, go to Section 2. For Death Report, go to Section 8.

Section 2. Information on signs and symptoms of ill or deceased person (passenger or crew)

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

FEVER (or recent history of) Temp: _____° F/C	severe vomiting	unusual bleeding
rash	severe diarrhea	obviously unwell
conjunctivitis/eye redness	headache	asymptomatic
persistent cough	neck stiffness	other
sore throat	decreased consciousness	(describe: _____)
difficulty breathing / shortness of breath	recent onset of focal weakness and /	
	or paralysis	

Brief history of present illness:
 If exposed to ill animals or birds, describe nature of contact:
 If exposed to ill person, ill persons' diagnoses or description of illness:

Are there other people on the plane with similar illness? Yes if yes, where? No
 Other exposures (chemical, powder, radiation, etc.): No Yes
 Does traveler have FEVER (or recent fever history) AND at least one other sign/symptom/condition listed above?
 NO (STOP HERE)

NO (but you are concerned illness may be of public health significance) (Proceed to next sections)

Section 6. Traveling companions & other contacts of ill or deceased person

Section 3. Pertinent medical history

Do you have underlying medical conditions that could explain your current symptoms? **YES, USE ANOTHER ILLNESS SCREENING AND RESPONSE WORKSHEET FOR EACH.** No Yes

Are you currently taking _____ (describe)

Section 7. Flight information

Airline & Flight #	Departure Airport	Departure Date & Time	Arrival Airport	Arrival Date & Time	Seat #	Flight Duration
CURRENT FLIGHT:						
PREVIOUS AND UPCOMING CONNECTING FLIGHTS:						

Section 4. History of current illness

I. Fever History: Paternal/Last name: _____ First name: _____ Type of traveler: Crew Passenger
 Date of fever onset: ___/___/___ Country of birth: _____
 If you measured your temperature during this illness, what was your maximum temperature? _____° F/C

II. Rash History: Male Female Date of birth: (mm / dd / yyyy) _____ Age (if Date of Birth Unknown): Days Weeks Months Years
 Date of rash onset: ___/___/___

For deceased persons, go to Section 9. Otherwise, continue below:

Where did the rash start? Head Trunk Extremities Other

Current distribution of rash: Head Trunk Extremities Other

Appearance of rash: Red-raised Red-flat Fluid- or pus-filled Other

Passenger had contact with someone with a rash/known chickenpox/measles/rubella in the last 3 weeks? Yes No
 Home address? _____ Permanent number? Yes No
 If not permanent, home phone #: _____

III. Respiratory Illness History: Home address _____ Home City: ___/___/___ Home State/Province: _____ Home Zip/Postal Code: _____ Home Country (Country of Residence): No Yes
 Cough with blood? No Yes onset: (mm / dd / yyyy) _____
 If (Country of residence) _____ Passport country: _____
 days months weeks years

IV. Gastrointestinal Illness History: Home State/Province: _____ Home Zip/Postal Code: _____ Home Country (Country of Residence): No Yes
 Diarrhea: _____ Date onset: ___/___/___ _____
 Vomiting: _____ Date onset: ___/___/___ _____
 Number of times in past 24 hrs? _____
 With blood? No Yes

Emergency contact name:	Emergency contact relationship:	Emergency contact phone:
Section 9. General information about the deceased person onboard the flight		
Date of death: _____ (mm / dd / yyyy)	Time of death (24 hours) : _____ (hh : mm)	
Suspected cause of death: If infectious disease is suspected as a contributing cause of death, then complete ALL sections of this form.		
Medical examiner notified? Yes No	Medical examiner name:	Medical examiner telephone:
		Name of person body released to:
Title of person body released to:	Agency:	Office telephone:
		Cell:
		Email:

Public reporting burden of this collection of information is estimated to average 6 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB Control Number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA 0920-xxxx.