

## Section 1. Quarantine station notification

QARS Unique ID #:		CDC User ID :	
Port of Entry:		State:	
Person notifying CDC:		Phone:	Email:
Agency notifying CDC:	Date of initial notification to CDC: ____/____/____ mm dd yyyy	Time of initial notification to CDC (24 hrs): ____:____ hh : mm	
Type of notification: <input type="checkbox"/> Traveler illness <input type="checkbox"/> Traveler death		Type of traveler: <input type="checkbox"/> Passenger <input type="checkbox"/> Crew	
When was the QS notified?: <input type="checkbox"/> Before any travel was initiated <input type="checkbox"/> In U.S. jurisdiction <input type="checkbox"/> In foreign jurisdiction <input type="checkbox"/> During travel <input type="checkbox"/> Prior to boarding conveyance <input type="checkbox"/> While traveler was on a conveyance <input type="checkbox"/> Inbound to or within U.S. states and territories <input type="checkbox"/> Outbound from U.S. states and territories <input type="checkbox"/> After disembarking conveyance <input type="checkbox"/> After travel completed (reached final destination for that leg of trip) <input type="checkbox"/> In U.S. jurisdiction <input type="checkbox"/> In foreign jurisdiction		Conveyance type*: <input type="checkbox"/> Commercial <input type="checkbox"/> foreign-based carrier <input type="checkbox"/> U.S.-based carrier <input type="checkbox"/> Private <input type="checkbox"/> Charter <input type="checkbox"/> Cargo <input type="checkbox"/> Other  *If ill/deceased person also traveled via <input type="checkbox"/> Land and/or <input type="checkbox"/> Maritime conveyances, please fill out the appropriate form and attach  Was the travel domestic or international?: <input type="checkbox"/> U.S. domestic travel only (U.S. states and territories) <input type="checkbox"/> International travel (could include domestic portion) <input type="checkbox"/> No travel done	

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

### Signs, Symptoms, and Conditions (check all that apply):

<input type="checkbox"/> <b>FEVER</b> ( $\geq 100^{\circ}\text{F}$ or $\geq 38^{\circ}\text{C}$ ) OR history of fever in the past 72 hours  Temperature: _____ <sup>o</sup> F/C Onset date: ____/____/____ Maximum measured temperature: _____ <sup>o</sup> F/C  <input type="checkbox"/> History of fever (not measured) <input type="checkbox"/> Feel warm to the touch  <input type="checkbox"/> Rash Onset date: ____/____/____ Where rash started: <input type="checkbox"/> Head/neck <input type="checkbox"/> Trunk <input type="checkbox"/> Extremities Current distribution: <input type="checkbox"/> Head/neck <input type="checkbox"/> Trunk <input type="checkbox"/> Extremities Appearance: <input type="checkbox"/> Red-flat <input type="checkbox"/> Red-raised <input type="checkbox"/> Fluid/pus-filled <input type="checkbox"/> Other _____  <input type="checkbox"/> Conjunctivitis/eye redness  <input type="checkbox"/> Coryza/runny nose	<input type="checkbox"/> Persistent cough Onset date: ____/____/____ <input type="checkbox"/> With blood <input type="checkbox"/> Without blood  <input type="checkbox"/> Sore throat  <input type="checkbox"/> Difficulty breathing/shortness of breath  <input type="checkbox"/> Swollen glands Location: <input type="checkbox"/> Head/neck <input type="checkbox"/> Armpit <input type="checkbox"/> Groin  <input type="checkbox"/> Severe vomiting Onset date: ____/____/____ Number of times in past 24 hrs? _____  <input type="checkbox"/> Severe diarrhea Onset date: ____/____/____ Number of times in past 24 hrs?: _____  <input type="checkbox"/> Jaundice Onset date: ____/____/____  <input type="checkbox"/> Headache	<input type="checkbox"/> Neck stiffness  <input type="checkbox"/> Decreased consciousness  <input type="checkbox"/> Recent onset of focal weakness and/or paralysis  <input type="checkbox"/> Unusual bleeding  <input type="checkbox"/> Obviously unwell  <input type="checkbox"/> Injury  <input type="checkbox"/> Chronic condition  <input type="checkbox"/> Asymptomatic  <input type="checkbox"/> Other: _____ _____ _____
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Does anyone else on the plane have similar illness?:  No     Yes     Unknown    (If yes, please fill in a new form for each person in the cluster.)

### Presumptive Diagnosis:

- Disease of public health interest or any death (**Proceed to next section**)  
 Condition of public health interest/unknown or cluster, needs follow-up (**Proceed to next section**)  
 Condition not requiring public health follow-up (**STOP HERE**)



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



**Section 3. Pertinent medical history of ill person**

Relevant history: present illness, other medical problems, vaccinations, etc.:

Traveler has taken:	<input type="checkbox"/> Antibiotic/antiviral in the <b>past week</b>	Medication(s) taken:	Date(s) started:
	<input type="checkbox"/> Fever reducing medications in the <b>past 12 hours</b> (e.g. acetaminophen, ibuprofen, aspirin)	1. _____	1. ____/____/____
	<input type="checkbox"/> Other	2. _____	2. ____/____/____
		3. _____	3. ____/____/____

**Section 4. General information about the ill or deceased person**

Last/paternal name:		First/given name:	
Middle name:	Maternal name (if applicable):	Other names used (e.g., former name, alias):	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth: ____/____/____ mm dd yyyy	Age (if date of birth unknown):	<input type="checkbox"/> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years
Country of birth:	Passport country/issuing state:	Passport/domestic ID document #:	Alien #:

**For deceased persons, go to Section 5. Otherwise, continue below.**

Home address:	City:	State/province:	Zip/postal code:
Country of residence:	Home phone:	If visiting, total duration of U.S. stay:	<input type="checkbox"/> days <input type="checkbox"/> months <input type="checkbox"/> weeks <input type="checkbox"/> years
Contact in U.S. - Address/hotel: <input type="checkbox"/> Same as home address above		E-mail:	
Contact in U.S. - City:	Contact in U.S. - State/territory:	Contact phone in U.S.:	<input type="checkbox"/> Cell
Emergency contact name:	Emergency contact relationship:	Emergency contact phone:	

**Section 5. Flight information**

Airline & Flight #	Departure Airport	Departure Date	Arrival Airport	Arrival Date	Seat #	Flight Duration
<b>CURRENT FLIGHT:</b>						
<b>PREVIOUS AND UPCOMING CONNECTING FLIGHTS:</b>						

**Section 6. Additional information about deceased person**

Date of death:	____/____/____ mm dd yyyy	Time of death (24 hours):	____:____ hh : mm
Suspected cause of death before referral to medical examiner, if body released:			
Body released to medical examiner?: <input type="checkbox"/> Yes <input type="checkbox"/> No	Medical examiner telephone:	City/Country:	
Determined cause of death (by medical examiner or other):			

**For deceased persons for whom the suspected cause of death is NOT a communicable disease, stop here. Otherwise, continue to Section 7.**

Cities/states/countries visited in the last	1	2	3	4
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**Section 7. Exposure and contact history of ill or deceased person**

Exposures	Exposure to ill persons? <input type="checkbox"/> Yes <input type="checkbox"/> No	Exposure to animals?*	Visited rural areas?	Other exposures (chemical, drug ingestion, etc):
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

\*zoos, bush meat, poultry markets, farms, backyard animals

Describe relevant exposures:

Are any traveling companions ill?:  No  Yes  N/A (no companions)      If yes, how many are ill: \_\_\_\_\_  
**If yes, use a separate illness screening and response worksheet for each.**

**Section 8: Disposition of ill person**

Ill person was (check all that apply):	<input type="checkbox"/> Released to continue travel	<input type="checkbox"/> Advised to seek medical care	<input type="checkbox"/> Recommended to not continue travel	
	<input type="checkbox"/> Seen by EMS	<input type="checkbox"/> Denied boarding	<input type="checkbox"/> Quarantine Order issued	<input type="checkbox"/> Isolation Order issued
	<input type="checkbox"/> Detained by ICE/CBP, location: _____			
	<input type="checkbox"/> Transported to hospital ( <input type="checkbox"/> MOA activated): _____			
	<input type="checkbox"/> Transported to non-hospital location: _____			
<input type="checkbox"/> Other: _____				

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 0920-0821