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

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: ☐ Traveler illness ☐ Traveler death

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

When was the QS notified?:
- ☐ Before any travel was initiated
  - ☐ In U.S. jurisdiction
  - ☐ In foreign jurisdiction
- ☐ During travel
  - ☐ Prior to boarding conveyance
  - ☐ While traveler was on a conveyance
    - ☐ Inbound to or within U.S. states and territories
    - ☐ Outbound from U.S. states and territories
  - ☐ After disembarking conveyance
- ☐ After travel completed (reached final destination for that leg of trip)
  - ☐ In U.S. jurisdiction
  - ☐ In foreign jurisdiction

Conveyance type*:
- ☐ Personal vehicle
  - ☐ Company owned
  - ☐ Rental
- ☐ Public conveyance bus/van
- ☐ Commercial cargo vehicle
- ☐ Pedestrian/Bike
- ☐ Ambulance
- ☐ Train
- ☐ Other

*If ill/deceased person also traveled via ☐ Air and/or ☐ Maritime conveyances, please fill out the appropriate form and attach

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

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

☐ **FEVER** (≥100°F or ≥38°C)
OR history of fever in the past 72 hours

Temperature: _____ ^{0} F/C
Onset date: _____/_____/_____
Maximum measured temperature: _____ ^{0} F/C

☐ History of fever (not measured)
☐ Feel warm to the touch

☐ Rash
Onset date: _____/_____/_____
Where rash started:
☐ Head/neck ☐ Trunk ☐ Extremities
Current distribution:
☐ Head/neck ☐ Trunk ☐ Extremities
Appearance:
☐ Red-flat ☐ Red-raised ☐ Fluid/pus-filled
☐ Other _____

☐ Conjunctivitis/eye redness

☐ Coryza/runny nose

☐ Persistent cough
Onset date: _____/_____/_____
☐ With blood ☐ Without blood

☐ Sore throat

☐ Difficulty breathing/shortness of breath

☐ Swollen glands
Location: ☐ Head/neck ☐ Armpit ☐ Groin

☐ Severe vomiting
Onset date: _____/_____/_____
Number of times in past 24 hrs? _____

☐ Severe diarrhea
Onset date: _____/_____/_____
Number of times in past 24 hrs?: _____

☐ Jaundice
Onset date: _____/_____/_____

☐ Headache

☐ Neck stiffness

☐ Decreased consciousness

☐ Recent onset of focal weakness and/or paralysis

☐ Unusual bleeding

☐ Obviously unwell

☐ Injury

☐ Chronic condition

☐ Asymptomatic

☐ Other: _____

_____

_____

If traveling by conveyance, does anyone else have similar illness?: ☐ No ☐ Yes ☐ Unknown (If yes, please fill in a new form for each person in the cluster.)

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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)**

Section 3. Pertinent medical history of ill person

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

Traveler has taken:	Medication(s) taken:	Date(s) started:
☐ Antibiotic/antiviral in the **past week**	1. _____	1. ____/____/_____
☐ Fever reducing medications in the **past 12 hours** (e.g. acetaminophen, ibuprofen, aspirin)	2. _____	2. ____/____/_____
☐ Other	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: ☐ Male ☐ Female	Date of birth: _____/_____/_____ mm dd yyyy	Age (if date of birth unknown): ☐ days ☐ weeks ☐ months ☐ years	
Country of birth:	Border commuter: ☐ Yes ☐ No ☐ Unknown	Frequency of border crossing: _____ times/ ☐ day ☐ week ☐ month ☐ year	
Passport country:	Passport country/issuing state:	Passport/domestic ID document #:	Visa?: ☐ Yes ☐ No

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

Home address:	City:	State/province:	Zip/postal code:
Country of residence:	Home telephone:	If visiting, total duration of U.S. stay: ☐ weeks ☐ years ☐ days ☐ months	
Contact in U.S. - Address/hotel: ☐ Same as home address above		E-mail:	
Contact in U.S. - City:	Contact in U.S. - State/territory:	Contact phone in U.S.: ☐ Cell Number of days reachable at contact phone:	
Emergency contact name:	Emergency contact relationship:	Emergency contact phone:	

Section 5. Border Crossing Information

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

Attempted entry outside an official POE?: ☐ No ☐ Yes ☐ Unknown	Contact information collected on conveyance passengers/driver(s)?: ☐ No ☐ Yes

From (City/Country)	Departure date	To (City/Country)	Arrival date	Significant stops	Name of commercial carrier, if applicable	Bus/Train #	Seat #
Current Segment:							
Past & Upcoming Segments:							

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Section 6. General information about the 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?: ☐ Yes ☐ 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.

Section 7. Exposure and contact history of ill or deceased person

Cities/states/countries visited in the last **3 WEEKS**	1.	2.	3.	4.

Exposures:	Exposure to ill persons? ☐ Yes ☐ No	Exposure to animals? * ☐ Yes ☐ No	Visited rural areas? ☐ Yes ☐ No	Other exposures (chemical, drug ingestion, etc): ☐ Yes ☐ 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 ill: _____

If yes, use another illness screening and response worksheet for each.

Section 8. Disposition of ill person

Ill person was (check all that apply):

☐ Released to continue travel ☐ Advised to seek medical care ☐ Recommended to not continue travel
☐ Seen by EMS ☐ Denied entry ☐ Quarantine Order issued ☐ Isolation Order issued
☐ Detained by ICE/CBP, location: _____
☐ Transported to hospital (☐ MOA activated): _____
☐ Transported to non-hospital location: _____
☐ Other: _____

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