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| **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: □ Illness □ Death | | | | When was the Quarantine Station notified?:  □ Before any travel was initiated  □ During travel  □ Prior to boarding conveyance  □ While traveler was on a conveyance  □ After disembarking conveyance  □ After travel completed (reached final destination for that leg of trip)  □ Unknown | | | | | |
| Type of traveler: □ Passenger □ Crew | | | |
| Where was the traveler when the QS was notified?:  □ In U.S. jurisdiction / Inbound  □ In foreign jurisdiction / Outbound  □ Unknown | | | |
| **NOTE**: If ill/deceased person also traveled via □ Land and/or □ Maritime conveyances, please fill out the appropriate form and attach | | | | | | | | | |
| **Section 2. Pertinent medical history of ill or deceased person** | | | | | | | | | |
| Relevant history: present illness, other medical problems, vaccinations, overseas physician diagnosis, etc.: | | | | | | | | | |
| Traveler has taken:  □Antibiotic/antiviral/antiparasitic(s) in the **past week**; list with date(s) started: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □Fever-reducing medications (e.g. acetaminophen, ibuprofen) in the **past 12 hrs**; list with time of last dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Other medications (related to current symptoms/illness); list with date(s) started: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| **Relevant Exposures** **in the Past 3 Weeks:** | | | | | | | | | |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | Village/City/State | Province/Country | Arrival Date | Exposure to ill persons? | Exposure to animals? | Other exposures (chemical, drug ingestion, etc)? | |  |  |  | □ No  □Yes, \_\_\_\_\_\_\_\_\_\_\_\_ | □ No  □Yes, \_\_\_\_\_\_\_\_\_\_\_\_ | □ No  □Yes, \_\_\_\_\_\_\_\_\_\_\_\_ | |  |  |  | □ No  □Yes, \_\_\_\_\_\_\_\_\_\_\_\_ | □ No  □Yes, \_\_\_\_\_\_\_\_\_\_\_\_ | □ No  □Yes, \_\_\_\_\_\_\_\_\_\_\_\_ | |  |  |  | □ No  □Yes, \_\_\_\_\_\_\_\_\_\_\_\_ | □ No  □Yes, \_\_\_\_\_\_\_\_\_\_\_\_ | □ No  □Yes, \_\_\_\_\_\_\_\_\_\_\_\_ | |  |  |  | □ No  □Yes, \_\_\_\_\_\_\_\_\_\_\_\_ | □ No  □Yes, \_\_\_\_\_\_\_\_\_\_\_\_ | □ No  □Yes, \_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
| **Signs, Symptoms, and Conditions (check all that apply):** | | | | | | | | | |
| □ FEVER(≥100°F or ≥38°C) **OR**  feeling feverish/having chills in past 72 hrs  Onsetdate: **\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_**  Current temperature: \_\_\_\_\_\_0 F/C  □ Rash  Onset date: **\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_** | | | □ Difficulty breathing/shortness of breath  Onset date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_  □ Swollen glands  Onset date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_  Location: □ Head/neck □ Armpit □ Groin | | | □ Decreased consciousness  Onset date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_  □ Recent onset of focal weakness  and/or paralysis  Onset date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ | | | |
| Appearance:  □ Maculopapular □ Vesicular/Pustular  □ Purpuric/Petechial □ Scabbed □ Other­­­­­­­­­­­­­­­­­­­­­  □ Conjunctivitis/eye redness  Onset date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_  □Coryza/runny nose | | | □ Vomiting  Onset date:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_  Number of times in past 24 hrs? **\_\_\_\_\_\_**  □ Diarrhea  Onset date:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_  Number of times in past 24 hrs?: \_\_\_\_\_\_ | | | □ Unusual bleeding  Onset date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_  □ Obviously unwell    □ Injury | | | |
| Onset date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_  □ Persistent cough  Onset date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_  □ With blood □ Without blood | | | □ Jaundice  Onset date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_  □ Headache  Onset date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ | | | □ Chronic condition  □ Asymptomatic  □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| □ Sore throat  Onset date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ | | | □ Neck stiffness  Onset date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |

Form Approved

OMB Control No.0920-XXXX

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| **Deceased Persons:** | | | | | | Date of Death: | | | | \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_  mm dd yyyy | | | | | | | | | | Time of death (24 hours): | | | | *\_\_\_\_*\_:*\_\_\_\_\_*  hh : mm | |
| **Presumptive Diagnosis or Cause of Death:** | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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 | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Response or Info Only:**  □ Requires DGMQ Response & Follow-up **(Proceed to next section)**  □ Information Report Only / No Follow-up needed **(STOP HERE)** | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Section 3. 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: | | | | Passport country/citizenship: | | | | | | | Type of ID: | | | | | | 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: | | | | | | □ Days □ Months  □ Weeks □ Years | | |
| 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 # of days reachable at contact phone: \_\_\_\_\_ | | | | | | | | |
| Emergency contact name: | | | | | | | | Emergency contact relationship: | | | | | | | | | Emergency contact phone: | | | | | | | | |
| **Section 4. Flight information** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Type\* | Domestic or Int’l? | | Airline | | | | | | Flight # | | | Departure Airport  Code | | | | Departure Date | | | Arrival Airport  Code | | Arrival Date | | | Seat # | Flight Duration |
| **CURRENT FLIGHT:** | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | |  | | | | | |  | | |  | | | |  | | |  | |  | | |  |  |
| **PREVIOUS AND/OR UPCOMING FLIGHTS:** | | | | | | | | | | | | | | | | | | | | | | | | | |
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| \***C/FB** = Commercial, foreign-based carrier **C/US** = Commercial, U.S.-based carrier **P** = Private  **CH** = Charter **CG** = Cargo  **O** = Other | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Section 5: Disposition of ill/deceased person** | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Ill person was (check all that apply):** | | | | | | | | | | | | | | | **Deceased Person:** | | | | | | | | | | |
| □ Released to continue travel  □ Advised to seek medical care  □ EMS responded  □Recommended to not travel  □ Transported to hospital (□MOA activated): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Transported to non-hospital location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □Detained by law enforcement, location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □Denied entry by law enforcement  □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | Body released to medical examiner?: □ Yes □ No  Medical examiner telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City/State/Country: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |

This data collection is mandatory. Public reporting burden of this collection of information is estimated to average 15 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 0920-0134.