Air 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: ☐ Illness ☐ Death

Type of traveler: ☐ Passenger ☐ Crew

Where was the traveler when the QS was notified?:
- ☐ In U.S. jurisdiction / Inbound
- ☐ In foreign jurisdiction / Outbound
- ☐ Unknown

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

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
Onset date: _____/_____/_____
Current temperature: _____ ⁰ F/C

☐ Rash
Onset date: _____/_____/_____
Appearance:
☐ Maculopapular ☐ Vesicular/Pustular
☐ Purpuric/Petechial ☐ Scabbed ☐ Other

☐ Conjunctivitis/eye redness
Onset date: _____/_____/_____

☐ Coryza/runny nose
Onset date: _____/_____/_____

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

☐ Sore throat
Onset date: _____/_____/_____

☐ Difficulty breathing/shortness of breath
Onset date: _____/_____/_____

☐ Swollen glands
Onset date: _____/_____/_____
Location: ☐ Head/neck ☐ Armpit ☐ Groin

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

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

☐ Jaundice
Onset date: _____/_____/_____

☐ Headache
Onset date: _____/_____/_____

☐ Neck stiffness
Onset date: _____/_____/_____

☐ Decreased consciousness
Onset date: _____/_____/_____

☐ Recent onset of focal weakness and/or paralysis
Onset date: _____/_____/_____

☐ Unusual bleeding
Onset date: _____/_____/_____

☐ Obviously unwell

☐ Injury

☐ Chronic condition

☐ Asymptomatic

☐ Other: _____
_____
_____

Form Approved
OMB Control No.0920-0134
Exp XX/XX/XXXX

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:									

***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):

☐ 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: _____

Deceased Person:

Body released to medical examiner?: ☐ Yes ☐ No

Medical examiner telephone: _____

City/State/Country: _____