



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



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

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"/> Illness <input type="checkbox"/> Death <input checked="" type="checkbox"/> Traveler Follow up	When was the Quarantine Station notified?:		
Type of traveler: <input type="checkbox"/> Passenger <input type="checkbox"/> Crew	<input type="checkbox"/> Before any travel was initiated <input type="checkbox"/> During travel <input type="checkbox"/> Prior to boarding conveyance <input type="checkbox"/> While traveler was on a conveyance <input type="checkbox"/> After disembarking conveyance <input type="checkbox"/> After travel completed (reached final destination for that leg of trip) <input type="checkbox"/> Unknown		
Where was the traveler when the QS was notified?: <input type="checkbox"/> In U.S. jurisdiction / Inbound <input type="checkbox"/> In foreign jurisdiction / Outbound <input type="checkbox"/> Unknown			

Commented [Author1]: Added to enable the use of this form for public health entry compliance checks that require follow-up with the SLHD.

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)?
			<input type="checkbox"/> No <input type="checkbox"/> Yes,	<input type="checkbox"/> No <input type="checkbox"/> Yes,	<input type="checkbox"/> No <input type="checkbox"/> Yes,

Relevant Vaccinations

Traveler up to date on relevant vaccinations Yes No Vaccinated with NON-WHO or NON-FDA approved vaccine Unknown
 Vaccine Type: _____; Dose 1 date: ____/____/____; Manufacturer: _____; Dose 2 Date: ____/____/____; Manufacturer: _____; Dose 3 date: ____/____/____
 Information Source: Vaccine card Medical Record Vaccine Digital Passport IATA Travel Pass State Records Traveler Recollection Other
 Specify: _____

Commented [Author2]: Added to enable tracking of vaccination status for ill/deceased persons as well as vaccination status of travelers undergoing compliance checks for revised testing and vaccination requirements.

Relevant Testing

Disease tested: _____ Testing Method: _____ Specimen Source: _____ Specimen Collection Date: _____ Date Lab Test Available: _____ Interpretations of Results: _____
 Comments: _____

Commented [Author3]: This information will be reviewed in initial compliance check and added to this section of this form if passenger is noncompliant.

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

<input type="checkbox"/> FEVER ($\geq 100^{\circ}\text{F}$ or $\geq 38^{\circ}\text{C}$) OR feeling feverish/having chills in past 72 hrs Onset date: ____/____/____ Current temperature: ____° F/C	<input type="checkbox"/> Difficulty breathing/shortness of breath Onset date: ____/____/____	<input type="checkbox"/> Decreased consciousness Onset date: ____/____/____
<input type="checkbox"/> Rash Onset date: ____/____/____ Appearance: <input type="checkbox"/> Maculopapular <input type="checkbox"/> Vesicular/Pustular <input type="checkbox"/> Purpuric/Petechial <input type="checkbox"/> Scabbed <input type="checkbox"/> Other	<input type="checkbox"/> Swollen glands Onset date: ____/____/____ Location: <input type="checkbox"/> Head/neck <input type="checkbox"/> Armpit <input type="checkbox"/> Groin	<input type="checkbox"/> Recent onset of focal weakness and/or paralysis Onset date: ____/____/____
<input type="checkbox"/> Conjunctivitis/eye redness Onset date: ____/____/____	<input type="checkbox"/> Vomiting Onset date: ____/____/____ Number of times in past 24 hrs? ____	<input type="checkbox"/> Unusual bleeding Onset date: ____/____/____
<input type="checkbox"/> Coryza/runny nose Onset date: ____/____/____	<input type="checkbox"/> Diarrhea Onset date: ____/____/____ Number of times in past 24 hrs?: ____	<input type="checkbox"/> Obviously unwell
<input type="checkbox"/> Persistent cough Onset date: ____/____/____ <input type="checkbox"/> With blood <input type="checkbox"/> Without blood	<input type="checkbox"/> Jaundice Onset date: ____/____/____	<input type="checkbox"/> Injury
	<input type="checkbox"/> Headache Onset date: ____/____/____	<input type="checkbox"/> Chronic condition
	<input type="checkbox"/> Loss of Sense of Taste or Smell	<input type="checkbox"/> Asymptomatic
		<input type="checkbox"/> Other: _____

Commented [Author4]: Added to provide symptom that is specific to COVID-19.

<input type="checkbox"/> Sore throat Onset date: ____/____/____	Onset date: ____/____/____
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Deceased Persons:	Date of Death: ____/____/____ mm dd yyyy	Time of death (24 hours): ____:____ hh : mm
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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 or traveler who may need follow up

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/citizenship:	Type of ID:	ID document #: _____ Alien #: _____

Commented [Author5]: Added to enable the use of this form for public health entry compliance checks that require follow-up with the SLHD. Air passengers not compliant with CDC Orders would be asked questions in Section 3.

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 # 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 [MD] = Medevac RP = Repatriation O = Other

Section 5: Public Health Entry Requirements

Entry Requirement:
 Did traveler meet the US Global Public Health Entry Requirements: Yes No N/A - Please specify:
 Comments:

Commented [Author6]: Added to account for other types of flights that come to the United States

Commented [Author7]: Air passengers not compliant with CDC Orders would be asked questions in Section 5.

Section 6: Disposition of traveler/ill/deceased person

<p>Ill person was (check all that apply):</p> <input type="checkbox"/> Released to continue travel <input type="checkbox"/> Advised to seek medical care <input type="checkbox"/> EMS responded <input type="checkbox"/> Recommended to not travel <input type="checkbox"/> Transported to hospital (<input type="checkbox"/> MOA activated): _____ <input type="checkbox"/> Transported to non-hospital location: _____ <input type="checkbox"/> Detained by law enforcement, location: _____ <input type="checkbox"/> Denied entry by law enforcement <input type="checkbox"/> Information transmitted to state and/or local health departments	<p>Deceased Person:</p> Body released to medical examiner?: <input type="checkbox"/> Yes <input type="checkbox"/> No Medical examiner telephone: _____ City/State/Country: _____
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Commented [Author8]: Added to reflect that this form is being used for follow-up of Public Health Entry compliance checks.

Other: _____

Public reporting burden of this collection of information is estimated to average 5 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