

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



Section 1. Quarantine station notification										
QARS Unique ID #:				Port of Entry:			State:			
Person notifying CDC:				Phone:	Email:	Email:				
Agency notifying CDC: Date of initial				<u> </u>	Time of	Time of initial notification :				
notification to Cl				: mm d	d yyyy		OC (24 hrs): hh: mm			
Type of notification:	□ Illness □	Death \square	Traveler	Follow up	When was the Quarantine Station notified?:					
Type of traveler: □ Passenger □ Crew				☐ Before any travel was initiated						
Where was the traveler when the QS was notified?:				☐ During travel☐ Prior to boarding conveyance☐						
□ In U.S. jurisdiction / Inbound					☐ While traveler was on a conveyance					
□ In foreign jurisd		und			☐ After disembarking conveyance					
□ Unknown					☐ After travel completed (reached final destination for that leg of trip)					
NOTE: If ill/deceased r	person also trav	veled via ⊓	Land and	/or Maritin	□ Unknown ne conveyances, please fill out the appropriate form and attach					
Section 2. Pertine										
Relevant history: presen		-				an diagnosis, e	etc.:			
Traveler has taken:										
□ Antibiotic/antiviral/□ Fever-reducing med						with time of l	art dosay			
☐ Other medications (with time of it	ast dose:			
(3 Wooks			·	
T T T T T T T T T T T T T T T T T T T			Arrival		ures in the Past 3 Weeks:		Other		exposures (chemical, drug	
Village/City/State	Province/Co	ice/Country		Exposure	to ill persons?	Exposure to animals?		ingestion, etc)?		
		□ No			□ No		□No			
				□Yes,		□Yes,		□Yes,		
				Releva	ant Vaccinations					
Traveler up to date on rel				inated with No	ON-WHO or NON					
Vaccine Type: Information Source: □ Va	; Dose 1 date: _ accine card □ M	// Mai [edical Recor	nufacturer d □ Vacc	; Dose :	2 Date:// M	Ianufacturer zel Pass □ State	; Dose 3 date	::// veler Reco	Manufacturer	
Specify:	accine cara 🗀 ivi	realear Recor	u 🗆 vucc	ine Digital I as	33port = 17177 11av	or rass - State	records - 11a	veier Reed	nicetion - Other	
Diagram to to to	-4: M-4b4.	Const	: C		levant Testing	D-t	D-4- I -1- T-	-4 A :1-1-1	le: Interpretations	
of Results.	sung Memou:	spec	illen soul	.ce	Specified Collecti	ion Date:	Date Lab Te	st Avanabi	ie: interpretations	
Comments:										
		Sig	gns, Sym _]	ptoms, and (Conditions (chec	k all that app	oly):			
□ FEVER (≥100°F or ≥38°C) OR □ Difficulty breathing/shortness of breath feeling feverish/having chills in past 72 hrs Onset date: / / □ Decreased consciousness						200				
feeling feverish/having chills in past 72 hrs Onset date:			/		Onset date:/					
Onset date:/			,		D					
Onset date:/ □ Rash			////neck □ Armnit □		Recent onset of focal weakness and/or paralysis					
Onset date://			Onset			nset date:/				
Annegrance			□ Vomi	tina			□ Unucual bla	adina		
Appearance: □ Vomiting □ Maculopapular □ Vesicular/Pustular □ Onset date:			☐ Unusual bleeding // Onset date:				/			
□ Purpuric/Petechial □ Scabbed □ Other Number of times in			n past 24 hrs?							
□ Conjunctivitis/eye redness □ Diarrhea			□ Obviously unwell							
Onset date:/			Onse	Onset date:// Number of times in past 24 hrs?:			□ Injury			
□ Coryza/runny nose			Nun	nber of times in	n past 24 hrs?:					
Onset date:/ □ Jaundice				□ Chronic condition						
Dargistant asuah			Onse	et date:	//		- Agymentor	tio		
□ Persistent cough							□ Asymptoma	uc		

Onset date://_ □ With blood □ Without	Onset	☐ Headache Onset date://				□ Other:					
			f Sense of Ta								
□ Sore throat	o lise	Onset date:/									
Onset date://											
Deceased Persons:	Date of Death	ı:	/ /				Time	of death (24 hours)	: <u></u> :	
		mm		уууу						hh:	mm
Presumptive Diagnosis or	Cause of Death	:									
Does anyone else on the pla	□ Yes* □	Unkno	wn								
*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)											
•	* *	·	•	1					1611		
Section 3. General in	formation abo	out the III or	· decease	d pers				may ne	ed follo	w up	
Last/paternal name:			First/given			n name:					
Middle name:	ı	Maternal name (if applicab	ole):			Other na	ames used	(e.g., forn	ner name, alia	ıs):
Gender: □ Male	Date of	/ /		Age (if	date of bir	th u	nknown):			□ Days □	¬ Weeks
□ Female	birth:	mm dd	уууу	S .			,				□ Weeks □ Years
Country of birth:	Passport country/c		ype of ID:			ID	documer	nt #:		Alien #:	
		r	J1								
For deceased persons, go	to Section 5. Ot	herwise, contin	ue below.								
Home address:		City:				State/province:				Zip/postal code:	
Country of residence:		Home phone:				If visiting, total duration of			on of	□ Days □ Months	
						U.S. stay:					
Contact in U.S Address/h	notel:					E-mail:					
Contact in O.S Hudiess/1	iotei.	□ S	☐ Same as home address above			D mail.					
Contact in U.S City:		Contact in U.S	Contact in U.S State/territory:			Contact phone in U.S.:					
			•			☐ Cell # of days reachable at contact phone:					
Emergency contact name:	Emergency co	Emergency contact relationship:			Emergency contact phone:						
	,	iorgeney commerciations.mp.			8y g						
Section 4. Flight info	rmation										
Domestic		F1: 1 . #	Departure	e Airpor	t Depart	ture	Arriva	l Airport	Arriva	ıl g "	Flight
Type* or Int'l?	Airline	Flight #	Co	de	Date	e	C	ode	Date	Seat #	Duration
CURRENT FLIGHT:							_				
PREVIOUS AND/OR UPCO	MING FLIGHTS	S:									
*C/FP - Commoraid foreign boo	and corrier C/US -	Commercial IIS b	acad carriar	D - Deivot	o CH - Ch	ortor	CC - Corr	m MD = M	ladayaa DD	2 - Popotriotion	O - Other
*C/FB = Commercial, foreign-based carrier											
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:											
Section 6: Disposition of traveler/ill/deceased person											
Ill person was (check all that apply):				Deceased Person:							
□ Released to continue travel											
☐ Advised to seek medical care					Body released to medical examiner?: □ Yes □ No						
 □ EMS responded □ Recommended to not travel 					Medical examiner telephone:						
☐ Transported to hospital (☐ MOA activated):				Medicai examiner terephone.							
☐ Transported to non-hospital location:					City/State/Country:						
□ Detained by law enforcement, location:					, , ,						

☐ Denied entry by law enforcement	
☐ Information transmitted to state and/or local health departments	
□ Other:	

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 0920-1318