Form Approved
OMB Control No.0920-1318
Exp 6/30/2022

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 #:	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 □ Traveler Follow up

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, _____

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: __/__/__ Manufacturer _____
Information Source: □ Vaccine card □ Medical Record □ Vaccine Digital Passport □ IATA Travel Pass □ State Records □ Traveler Recollection □ Other Specify:_____

Relevant Testing

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

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

□ 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: _____/_____/_____

□ Decreased consciousness
Onset date: _____/_____/_____

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

□ Unusual bleeding
Onset date: _____/_____/_____

□ Obviously unwell

□ Injury

□ Chronic condition

□ Asymptomatic

Onset date: _____/_____/_____ □ With blood □ Without blood □ Sore throat Onset date: _____/_____/_____	□ Headache Onset date: _____/_____/_____ □ Loss of Sense of Taste or Smell Onset date: _____/_____/_____	□ Other: _____

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 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: □ 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 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:

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 □ EMS responded □ Recommended to not travel □ Transported to hospital (□ MOA activated): _____ □ Transported to non-hospital location: _____ □ Detained by law enforcement, location: _____	Body released to medical examiner?: □ Yes □ No Medical examiner telephone: _____ City/State/Country: _____

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