OMB Control Number: 1024-XXXX
Expiration Date: XX/XX/XXXX

National Park Service
Office of Public Health
Case Investigation and Outbreak Form

Paperwork Reduction Act Statement: We are collecting this information subject to the Paperwork Reduction Act (44 U.S.C. 3501) to provide park managers with the information needed to protect the health of the public. It is in your best interest to complete the form as thoroughly as possible in order for the park manager to respond to urgent outbreaks or events and prevent disease transmission and illnesses within or associated with National Parks. You are not required to respond to this or any other Federal agency-sponsored information collection unless it displays a currently valid OMB control number. OMB has approved this collection of information and assigned Control No. 1024-XXXX.

Estimated Burden Statement: Public Reporting burden for this form is approximately 20 minutes depending on the nature of the disease outbreak or event., including the time it takes for reviewing instructions and completing the form. Comments regarding this burden estimate or any aspect of this form should be sent to the Information Collection Clearance Officer, National Park Service, 12201 Sunrise Valley Drive Reston, VA 20192. Please do not mail your completed form to this address.

Section I. Demographic/Contact information

What is your primary/preferred language? ___________

1. Are you a:
   - ☐ NPS employee
   - ☐ Volunteer
   - ☐ Concessioner
   - ☐ Other NPS Partner
   - ☐ Visitor/public
   - ☐ Other ____

2	Last name	______________________________
3	First name	______________________________
4.	Address	______________________________
5	City	______________________________
6	County	______________________________
7	State	______________________________
8	Zip	______________________________
9	Country (if not U.S)	______________________________
10	Phone 1	______________________________
11	Phone 2	______________________________
12	E-mail address	______________________________

13. (If a surrogate is answering the questions), What is your relationship to the case?
   - ☐ Parent
   - ☐ Spouse or domestic partner
   - ☐ Sibling
   - ☐ Friend
   - ☐ Other, specify:

Questions below are intended for the case of interest. If you are answering as a surrogate, please state the response for the case and not yourself.

14. Gender:
- ☐ Male
- ☐ Female
- ☐ Transgender, non-binary, or another gender
- ☐ Prefer not to disclose

15. Date of Birth: __/__/____

Are you [they] Hispanic or Latino?
- ☐ YES
- ☐ NO

16. What is your [their] race? (Select one or more responses.)
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White
- ☐ Multiracial or Biracial
- ☐ A race/ethnicity not listed here

17. What is your [their] occupation? ______________________________

18. Do you [they] live in NPS park or concession housing?
- ☐ Yes
- ☐ No

If Yes, specify:

Section II. Travel and National Park Visitation Information

1. Name of National Park(s)/Monument(s) visited:

____

2. Name of park/monument and date(s) of visit(s) at each park:

Name	Date	Date
	___ / ___ / ___	___ / ___ / ___
	___ / ___ / ___	___ / ___ / ___
	___ / ___ / ___	___ / ___ / ___

3. Did you [they] travel from out of state or out of country to visit the National Park?
   - ☐ Yes
   - ☐ No

   If Yes, specify your [their] state/country of residence:

4. Which modes of transportation did you [they] take to get to the park(s) (select all that apply):
   - ☐ Car
   - ☐ Plane
   - ☐ Other, specify:
   - ☐ N/A

5. Did you [they] participate in any park tours?
   - ☐ Yes
   - ☐ No

   If Yes, specify:

6. Which of the following activities did you [they] participate in, or places did you [their] visit during your trip? (select all that apply):
   - ☐ Visitor's center
   - ☐ Museum
   - ☐ Gallery
   - ☐ Native American village (if yes, did they enter any of the dugout structures?)
   - ☐ Nature Centers
   - ☐ Horseback riding
   - ☐ Rock climbing
   - ☐ Hiking
   - ☐ Biking
   - ☐ Other: specify

7. Did you [they] stay overnight at or near the park(s) visited?

☐ Yes
☐ No

If Yes, specify (hotel, lodge, cabin, tent, backcountry, other):

8. How many different locations did you [they] stay (please provide details)?

Name (Location)	Dates Stayed	Type of Lodging

9. Were there other people who stayed overnight with you (e. g. in the same room, same campground, same party)?

☐ Yes
☐ No

9a. If Yes, for other attendees, please provide specific information:

Name	Relationship	Phone

9b. Were any of the other people you [they] stayed overnight with within the week before or after you [they] spent time with them?
For other attendees, specify:

Name	Describe illness

10. Were there other people whom you had close contact with (e.g., tour group members, day hiking partners, sexual partners, etc).

☐ Yes
☐ No

10a. If Yes, for other close contacts, please provide specific information:

Name	Relationship	Phone

10b. Were any of the other people who had close contact with you sick?
For other close contacts, specific

Name	Describe illness

11. Did you [they] travel to any other destinations in the two weeks prior to developing symptoms?

☐ Yes
☐ No

If Yes, specify city, state, location:

12. Did you [they] travel outside the U.S. in the two weeks prior to developing symptoms?

☐ Yes
☐ No

If Yes, specify location:

Section III. Clinical and Medical Care Information

1. Did you see a healthcare provider for this illness?
   - ☐ Yes
   - ☐ No
   - ☐ Not sure

   If Yes, specify with admission and discharge date:

2. Were you hospitalized?
   - ☐ Yes
   - ☐ No
   - ☐ Not sure

   If Yes, specify:

3. Dates of medical care related to this illness: ___/__/____ – ___/___/____

4. Name of medical facility: ____

5. Name of medical provider: ____

6. Contact Information for medical facility or provider: ____________________________

7. Address of medical facility: ____

8. Is the local/state health department aware of your illness?
   - ☐ Yes
   - ☐ No
   - ☐ Not sure

   If Yes, specify (points of contact, contact information):

9a. Date of illness onset: ____/____/_______

9b. Date of diagnosis: ____/____/_______

10. Duration of illness: ________________________

11. Date of suspected exposure: ____/____/_______

12. Did you experience any of the following signs or symptoms during your illness (select all that apply):

- ☐ Fever
- ☐ Chills
- ☐ Fatigue
- ☐ Muscle aches
- ☐ Headache
- ☐ Diarrhea
- ☐ Vomiting
- ☐ Blood in stool
- ☐ Abdominal cramps
- ☐ Nausea
- ☐ Coughing
- ☐ Congestion
- ☐ Sore throat
- ☐ Rash
- ☐ Difficulty breathing

Other, specify: ____

13. Were any clinical samples collected and tested (select all that apply) or any diagnostic tests done?:

- ☐ Blood
- ☐ Urine
- ☐ Stool
- ☐ Sputum
- ☐ Nasal swab
- ☐ Chest X-ray

Other, specify: ____

14. For any clinical testing done, indicate which test and whether the test results were: Positive, Negative, Inconclusive, Not sure

	Specimen	Date of collection	Test type	Results
Test 1:				
Test 2				
Test 3				

15. Were you [they] given a diagnosis (or multiple)?

- ☐ Yes
- ☐ No
- ☐ Not sure

If Yes, specify:

16. Was treatment initiated?

- ☐ Yes
- ☐ No
- ☐ Not sure

If Yes, specify the type of treatment:

17. Do any of the following apply to you or the person you are responding for?

- ☐ Pregnant
- ☐ Diabetes
- ☐ Adult >65 years old
- ☐ Child <5 years old
- ☐ High-dose corticosteroids
- ☐ Otherwise immunosuppressed (e.g. HIV, transplant recipient

Other ____

18. Do you [they] smoke?

- ☐ Yes
- ☐ No

If Yes, specify how much per day:

19. Have you ever been vaccinated against (insert relevant disease of concern)?

- ☐ Yes
- ☐ No
- ☐ Not sure

If Yes, specify date(s) of vaccine(s):

IV. Additional Comments

____

____

____

Appendix

NOTE TO REVIEWER: *Questions in the following sections below are examples of the questions that may be asked based on the specific outbreak/event.. Examples of exposures include bat, rodent, vector, foodborne illness, waterborne illness, bloodborne illness, and other person-to-person event.*

SUSPECTED ZOONOTIC DISEASE

1. Did you [they] have contact with any animals in the park (bite, scratch, pet, other)

☐ Yes
☐ No

If Yes, specify which type of contact:

2. What type of animal did you [they] have contact with? ________________________________

3. What parts of your [their] body came in contact with the animal?

____

4. Is the animal available for monitoring or testing?

☐ Yes
☐ No
☐ Not sure

If Yes, specify:

5. Have you been previously vaccinated against rabies?

☐ Yes
☐ No
☐ Not sure

If Yes, when: __/__/____

BAT EXPOSURES

1. Did you have any potential exposures to a bat (bite, scratch, or otherwise close exposure to your body)?

☐ Yes
☐ No
☐ Not sure

2. Was a bat seen in a building where you were?

☐ Yes
☐ No
☐ Not sure

3. How many bats were seen? ___

☐ Not sure

4. Did the bat have access to sleeping or incapacitated people?

☐ Yes
☐ No
☐ Not sure

If Yes, specify:

5. Date of bat entry: ____/____/_______ and time __:_

☐ Not sure

6. Is there evidence of long-term bat presence, including bat feces accumulations or urine stains?

☐ Yes
☐ No
☐ Not sure

RODENT AND VECTOR EXPOSURES

1. Did you see any evidence of rodents while in the park (droppings, nests, holes, gnaw marks, scattered food, etc.)

☐ Yes
☐ No
☐ Not sure

If Yes, indoors or outdoors and specify:

2. Did you attempt to clean up rodent droppings or other rodent evidence while in the park? (exposure includes cleaning, sweeping, sleeping, or any other activity where you might inhale dust or have close exposure to an area with rodent droppings)

☐ Yes
☐ No
☐ Not sure

If Yes, specify:

3. Did you experience any insect (flea, mosquito, kissing bug) or arachnid (spider, tick, scorpion) bites in the park?

- ☐ Yes
- ☐ No
- ☐ Not sure

If Yes, specify:

FOR FOODBORNE OR WATERBORNE ILLNESS

1. Did you spend time with anyone or have any household members that experienced a similar illness in the 3-days prior to your illness?

- ☐ Yes
- ☐ No
- ☐ Not sure

If Yes, specify:

2. Do you suspect a specific establishment or source of your illness?

- ☐ Yes
- ☐ No
- ☐ Not sure

If Yes, specify why:

3. Did you notify the suspected establishment or source?

- ☐ Yes
- ☐ No
- ☐ Not sure

4. Did you attend any special or organized group events while at the park?

- ☐ Yes
- ☐ No
- ☐ Not sure

If Yes, specify (including date):

5. Did you eat raw or undercooked meat, seafood, or shellfish?

☐ Yes
☐ No
☐ Not sure

If Yes, specify (including date):

6. Would you be willing to submit a stool sample for testing?

☐ Yes
☐ No
☐ Not sure

7. If foodborne illness is suspected or confirmed, please complete this four-day food history using the following daily template:

Day 1	Meal Time	Location of Meal	Food	Drink
Breakfast				
Lunch				
Dinner				
Other				

Day 2	Meal Time	Location of Meal	Food	Drink
Breakfast				
Lunch				
Dinner				
Other				

Day 3	Meal Time	Location of Meal	Food	Drink
Breakfast				
Lunch				
Dinner				
Other				

Day 4	Meal Time	Location of Meal	Food	Drink
Breakfast				
Lunch				
Dinner				
Other				

8. Did you drink water from a well, non-municipal, or a potentially unsafe water source (e.g., stream, lake)?

☐ Yes
☐ No
☐ Not sure

If Yes, specify:

9. Did you bathe or swim outside or in a potentially unsafe water source (e.g., stream, lake)?

10. Did you have any exposure to aerosolized water (e.g. hot tubs, misters, spa, sauna)?

☐ Yes
☐ No
☐ Not sure

If Yes, specify:

FOR NPS FOOD SERVICE WORKERS ONLY

1. What are your job duties? ____________________________

2. If you work with food, please describe which foods and what type of food handling you do:

____

3. Which food items served on __/__/____ did you handle or prepare?

____

4. What days and times did you work since __/__/____? ____________________________

5. Do you know of any other workers that are ill?

☐ Yes
☐ No
☐ Not sure

If Yes, specify:

SUSPECTED BLOODBORNE ILLNESS

1. Did you have exposure to human blood or other human fluids/waste at the park?

☐ Yes
☐ No
☐ Not sure

If Yes, specify (when and what):

PERSON-TO-PERSON ILLNESS

1. In the past 14 days, have you had contact with a person with a confirmed or suspected illness?

☐ Yes
☐ No
☐ Not sure

If Yes, specify: