



## 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: <input type="checkbox"/> Illness <input type="checkbox"/> Death <input 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			
Where was the traveler when the QS was notified?:		<input type="checkbox"/> During travel			
<input type="checkbox"/> In U.S. jurisdiction / Inbound		<input type="checkbox"/> Prior to boarding conveyance			
<input type="checkbox"/> In foreign jurisdiction / Outbound		<input type="checkbox"/> While traveler was on a conveyance			
<input type="checkbox"/> Unknown		<input type="checkbox"/> After disembarking conveyance			
		<input type="checkbox"/> After travel completed (reached final destination for that leg of trip)			
		<input type="checkbox"/> Unknown			
<b>NOTE:</b> If ill/deceased person also traveled via <input type="checkbox"/> Land and/or <input type="checkbox"/> 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:					
<input type="checkbox"/> Antibiotic/antiviral/antiparasitic(s) in the <b>past week</b> ; list with date(s) started: _____					
<input type="checkbox"/> Fever-reducing medications (e.g. acetaminophen, ibuprofen) in the <b>past 12 hrs</b> ; list with time of last dose: _____					
<input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Vaccinated with NON-WHO or NON-FDA approved vaccine <input type="checkbox"/> Unknown					
Vaccine Type: _____; Dose 1 date: ____/____/____ Manufacturer _____; Dose 2 Date: ____/____/____ Manufacturer _____; Dose 3 date: ____/____/____ Manufacturer _____					
Information Source: <input type="checkbox"/> Vaccine card <input type="checkbox"/> Medical Record <input type="checkbox"/> Vaccine Digital Passport <input type="checkbox"/> IATA Travel Pass <input type="checkbox"/> State Records <input type="checkbox"/> Traveler Recollection <input type="checkbox"/> 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):					
<input type="checkbox"/> <b>FEVER</b> ( $\geq 100^{\circ}\text{F}$ or $\geq 38^{\circ}\text{C}$ ) <b>OR</b> feeling feverish/having chills in past 72 hrs Onset date: ____/____/____ Current temperature: _____ <sup>o</sup> 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		<input type="checkbox"/> Jaundice Onset date: ____/____/____		<input type="checkbox"/> Injury	
				<input type="checkbox"/> Chronic condition	
				<input type="checkbox"/> Asymptomatic	

Onset date: ____/____/____ <input type="checkbox"/> With blood <input type="checkbox"/> Without blood  <input type="checkbox"/> Sore throat Onset date: ____/____/____	<input type="checkbox"/> Headache Onset date: ____/____/____  <input type="checkbox"/> Loss of Sense of Taste or Smell Onset date: ____/____/____	<input type="checkbox"/> Other: _____
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<b>Deceased Persons:</b>	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 #:

**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
<b>CURRENT FLIGHT:</b>									
<b>PREVIOUS AND/OR UPCOMING FLIGHTS:</b>									

\*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**

<p><b>Ill person was (check all that apply):</b></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: _____	<p><b>Deceased Person:</b></p> Body released to medical examiner?: <input type="checkbox"/> Yes <input type="checkbox"/> No  Medical examiner telephone: _____  City/State/Country: _____
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| <ul style="list-style-type: none"><li><input type="checkbox"/> Denied entry by law enforcement</li><li><input type="checkbox"/> Information transmitted to state and/or local health departments</li><li><input type="checkbox"/> Other:</li></ul> |  |
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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