

## Air Travel Illness or Death Investigation 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:					
Agency notifying CDC:  Date of initial notification to CDC					C: mm dd yyyy Time of initial notification to CDC (24 hrs):			DC (24		
Type of notification:	$\square$ Illness	$\square$ 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?:  □ In U.S. jurisdiction / Inbound □ In foreign jurisdiction / Outbound □ Unknown				<ul> <li>□ During travel</li> <li>□ Prior to boarding conveyance</li> <li>□ While traveler was on a conveyance</li> <li>□ After disembarking conveyance</li> <li>□ After travel completed (reached final destination for that leg of trip)</li> <li>□ Unknown</li> </ul>						
<b>NOTE</b> : If ill/deceased p	erson als	o traveled via	□ Land an	d/or □ Marit	ime conveyances	s, please fill ou	the appropri	ate form	and attach	
Section 2. Pertiner										
Relevant history: present Traveler has taken:  Antibiotic/antiviral/ Fever-reducing med Other medications (	antiparasi lications (	itic(s) in the <b>p</b> (e.g. acetamin	<b>ast week</b> ; lophen, ibup toms/illnes	list with date profen) in the ss); list with	e(s) started: e <b>past 12 hrs</b> ; list date(s) started: _	st with time of				
				evant Expo	sures in the Pas	t 3 Weeks:				
Village/City/State	Provinc	ce/Country	Arriv al Date	Exposure to ill persons?		Exposure t	o animals?	Other exposures (chemical, drugingestion, etc)?		
				□ No □Yes,		□ No □Yes,		□ No □Yes,		
Relevant Vaccinations  Traveler up to date on relevant vaccinations \( \text{Yes} \) \( \text{No} \) \( \text{Vaccinated with NON-WHO or NON-FDA approved vaccine} \( \text{Unknown} \) \( \text{Vaccine Type:} \) \( \text{; Dose 1 date:} \) \( / \) \( \text{Manufacturer} \) \( \text{; Dose 2 Date:} \) \( / \) \( \text{Manufacturer} \) \( \text{; Dose 3 date:} \) \( / \) \( \text{Manufacturer} \) \( \text{Inform Source:} \) \( \text{Vaccine card} \) \( \text{Ddeficition Date:} \) \( \text{Vaccine Pass} \) \( \text{State Records} \) \( \text{Traveler Recollection} \) \( \text{Other Specify:} \) \( \text{Relevant} \) \( \text{Testing} \) \( \text{Disease tested:} \) \( \text{Testing Method:} \) \( \text{Specimen Source:} \) \( \text{Specimen Collection Date:} \) \( \text{Date Lab Test Available:} \) \( \text{Interpretations of Results.} \)										
Comments:										
Signs, Symptoms, and Conditions (check all that apply):										
□ FEVER (≥100°F or ≥38° feeling feverish/having of hrs Onset date: _/	chills in pa / 0 F/C  /  /  Vesicular/P  □ Scabbed	ustular	□ Swol Ons Loc Gro □ Vom Ons Nur	iculty breathin ath Onset date  llen glands set date: Heacoin Heacoin set date: in the date:	/ / / I/neck □ Armpit □  / / / in past 24 hrs?		□ Decreased consciousness Onset date:/ / □ Recent onset of focal weakness and/or paralysis Onset date:/ / □ Unusual bleeding Onset date:/ / □ Obviously unwell			
☐ Conjunctivitis/eye redness ☐ Diarrhea Onset date:/ / Onset date: Number of t			set date:	// in past 24 hrs?:	□ Injury	□ Injury				

Coryza/runny nose Onset date:/	□ Jaundice	☐ Chronic condition
Persistent cough	Onset date:/	☐ Asymptomatic

Onset date:/  ☐ With blood ☐ Without blood				☐ Headache Onset date://			□ Other:						
				☐ Loss of Sense of Taste or Smell									
□ Sore throat Onset date: / /			On	nset date:	//	<u></u>							
Deceased	d Persons:	Date of Dea	ath:	/	/		Time of death (24						
		- 05		nm dd	уууу		hours): hh:mm						
_	·	or Cause of Deat											
_		plane have similar form for each person		o □ Yes*	□ Unkno	wn							
	se or Info Only:												
		sponse & Follow-u Only / No Follow-u			n)								
		information a			sed pers	on or tr	avele	er who may ne	eed follo	ow up			
	ernal name:						en name:						
Middle na	ame:		Maternal nam	Maternal name (if applicable):			Other names used (e.g., former name, alias):						
Gender:	□ Male	Date		/	Age (if	f date of bir	rth unl	known):		□ Days	□ Weeks		
	□ Female	of birth:	mm dd				□ Months □ Years						
Country of	of birth:	Passport country	y/citizenship:	enship: Type of ID:			ID document #:			Alien #:			
For dece	ased persons,	go to Section 5. C	Otherwise, con	tinue below	/•								
Home add	dress:		City:				State/province:			Zip/postal code:			
Country of	of residence:		Home phone:			I II S stav.			□ Months □ Years				
Contact i	in U.S Addres	ss/hotel:					E-n	nail:					
				$\ \square$ Same as home address above									
Contact in	in U.S City:		Contact in I	Contact in U.S State/territory:				Contact phone in U.S.:					
							☐ Cell # of days reachable at contact phone:						
Emergen	ncy contact name	2:	Emergency	Emergency contact relationship:			Emergency contact phone:						
Section	ı 4. Flight in	formation											
Type*	Domesti c or Int'l?	Airline	Flight #	I A	ure Airport Code	Depart Dat		Arrival Airport Code	Arriv l Date	Seat #	Flight Duration		
CURREN	NT FLIGHT:												
PREVIOUS AND/OR UPCOMING FLIGHTS:													
*C/FB = Commercial, foreign-based carrier C/US = Commercial, U.Sbased carrier P = Private CH = Charter CG = Cargo MD = Medevac RP = Repatriation O = Other													
Section 5: Public Health Entry Requirements													
<b>Entry Requirement:</b> 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?: $\square$ Yes $\square$ No
□ EMS responded	
□ Recommended to not travel	Medical examiner telephone:
$\Box$ Transported to hospital ( $\Box$ MOA activated):	-
☐ Transported to non-hospital location:	City/State/Country:
□ Detained by law enforcement, location:	

Denied entry by law enforcement	
Inform <del>ation transmitted to state and/or lo</del> cal 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 0920-0134